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NOTE.—The reader is requested to observe that the Plates will not always bear consecutive numbers. They have been printed for a smaller Atlas of Clinical Illustrations of Disease, which will be published on completion of the Archives, and their numbers refer to their position in that work.

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ARCHIVES OF SURGERY.

JULY, 1889.

RECORDS OF INTESTINAL OBSTRUCTION ; WITH ESPECIAL REFERENCE TO SYMPTOMS AND TREATMENT.

THERE are many and very important questions in reference to the diagnosis and treatment of intestinal obstructions which are still open to debate. As some of my readers may know, I have myself, for long, taken great interest in their discussion, and have already on several occasions published statements of my experience. It seems to me, however, that there is much still to be said, and that from the careful collation of facts we may yet hope for important increase of our knowledge. I therefore purpose in this and in subsequent papers to pass anew over the whole subject. In doing this, it will be my endeavour to make the facts as far as possible speak for themselves. I shall cite cases already published by others as well as by myself, and do my best to state them in such a manner that their lessons will be easily appreciated. A main object will be to test our rules of diagnosis. It is possible that in some respects these may be developed and made more definite, but, it is also possible, that they are already, in some directions, pushed beyond what our knowledge justifies. Next to the correct interpretation of symptoms, and based upon it, will come the establishment of rules of treatment. These must be adapted with

discrimination to the differing groups of cases. More particularly I shall seek to ascertain what are the indications for surgical interference, by way of operation, exploration, or otherwise. Although as stated, it is my intention to cite new facts and to recapitulate old ones in some detail, and although I shall seek to submit my opinions most rigidly to the test of facts, yet I will by no means profess that those opinions are not already formed. I can by no means go with some of my surgical friends, who write as if they thought the diagnosis of intestinal obstruction in its early stages an easy matter, more especially with those who insist upon the performance of early operations with much the same degree of confidence that is felt in reference to strangulated hernia. I do not believe that the diagnosis of what has been called "acute intestinal obstruction" can be made-out with certainty; nor do I think that that term is by any means an appropriate one, as applicable to any single group of abdominal cases. The symptoms which are supposed to indicate it may occur in connection with a variety of causes, some of them not implying any real obstruction at all. Suddenness of onset, severity of pain, vomiting, tenderness, and constipation constitute the group of symptoms which are by some considered to imply "acute abdominal obstruction." There are those who go even further than this, and boldly assert that the symptoms justify the diagnosis of a form of abdominal obstruction from which spontaneous recovery is scarcely possible, and that when they are present an operation is indicated.

The two surgeons who have expressed themselves the most definitely on this point are, first, my friend and colleague, Mr. Treves, to whose skill as a surgeon, and dexterity as an operator, I bear the most willing testimony, and Mr. Greig Smith, of Bristol.*

Mr. Treves writes: "With regard to the curative treatment, the only measure is laparotomy. It has been shown that in the first five at least, of the above-mentioned con-

* Since the above was written, an opportunity has occurred which enables me with much pleasure to extend this statement from personal observation to Mr. Greig Smith also.

ditions, spontaneous cure, while not absolutely impossible is yet so exceedingly improbable, that it cannot be considered when discussing the treatment of the case."

Mr. Grieg Smith expresses his opinion with equal positiveness.

The five conditions comprised by Mr. Treves in the above statement are:—1. Peritoneal bands; 2. Omental cords; 3. The diverticulum; 4. Adherent appendix, or Fallopian tube; 5. Strangulation through slits or apertures. Mr. Treves adds, "I would urge that laparotomy should be performed as soon as the diagnosis is fairly clear, and if possible, *within the first twenty-four hours after the appearance of symptoms.*"

Now, in connection with these statements, I am prepared to offer two counter ones. I deny that it is ever possible to make more than the merest guess as to "acute strangulation by a band," in the early stage of the case; and I deny that acute obstruction is synonymous with strangulation by a band. To these denials I append an assertion, that the evidence is in favour of the belief that these forms of strangulation are often in early stages effectually relieved without operation; that, in fact, cases of recovery without operation, after very acute symptoms, are not uncommon. In corroboration of these statements, I may add that it is a not infrequent item in the past history of those in whom a fatal attack offers the opportunity for proof of the existence of a band, that the patient had recovered from one or more similar attacks in former years. I appeal further to the fact that hernial protrusions often slip back spontaneously, or with exceedingly little manipulation, and that in these internal strangulations the conditions are often such as to admit of the very easiest replacement. It is a mistake to suppose as these authors seem to do, that all strangulations by bands, &c., are from the first tight ones. In many, especially in those by a diverticulum, the space is large, there is no sharp edge, and it is not improbable that in the first instance the portion of bowel involved is quite small. It is only after strangulation has existed for some little time and more bowel has become involved, that the strangulation

becomes complete. Many a time at a post-mortem or an operation, the surgeon is astonished at the ease with which the involvement is reduced, and feels almost surprised that it had not slipped back spontaneously. As I have already said, clinical histories make it probable that such slipping back does often occur.

He who aims at operating within twenty-four hours will, I suspect, but very exceptionally find his diagnosis confirmed. It is not possible at that period to say whether or not obstruction (*i.e.*, obstipation) exists or not, and cases of gall-stones passing the common duct, of enteritis, of acute typhilitis and acute peritonitis may, each in turn, present all the other symptoms with quite equal severity.

I cannot help believing that cases of most acute abdominal symptoms, lasting for twenty-four hours, or much more, often recover under ordinary means; and it appears to me an assumption not warranted by the facts that none of these are instances of the spontaneous reduction of internal strangulations. It is not the fact that the severity of the symptoms during the first day is a measure of the real urgency of the case, or a safe guide to its diagnosis.

In what has just been said, allusion is made to reduction of a strictly spontaneous character, but if we have recourse to artificial aid, then I believe that a considerable proportion of cases of internal strangulation would be successfully replaced, if the measures were resorted to with promptness in an early stage. On this point, I have but to refer to what I have formerly said as to abdominal taxis. It is precisely in these cases of strangulation by bands that taxis is likely to succeed. It was in the *Medical Times* for 1858, exactly thirty years ago, that I first wrote on what I then ventured to call Abdominal taxis, as a method of treatment for cases of supposed internal strangulation. It was intended to comprise under that name various and somewhat differing details, having for their object the replacement by manipulation, or by altered position of the body, knuckles of intestine which had become twisted, had slipped behind bands, or in any other way had become subjected to mechanical compression. The term seemed appropriate in parallel contrast with that of Hernial taxis, as

in use for the manipulative reduction of external protrusions. It was not, however, by any means intended that abdominal taxis should end with manipulation only. On the contrary, perhaps its most important part consisted in altering the position of the patient's body, effecting its inversion, &c., and in these reversed positions subjecting it to vigorous succussion.

At the time that I wrote that paper I had taken great interest in some cases in which the abdominal cavity had been opened for the relief of obstruction, the unsuccessful result of which had naturally occasioned thought as to whether any other means could be devised. There was nothing absolutely new in any of the details of my proposal, but they had, I think, not previously been described and recommended in a systematic manner. With their novelty or otherwise I am not now in the least concerned, the sole question which I wish to bring forward being as to their usefulness. During the thirty years that have passed since the paper referred to was written, I have enjoyed a large range of experience both in hospitals and in private practice, and I have naturally taken a great interest in the treatment of abdominal obstructions. In the year 1871 a successful case of operation for intussusception led me to become a warm advocate for opening the abdomen in that form of the malady, but I still remained with but little zeal in reference to operations in cases where no positive diagnosis could be made. My opinions on this latter point have been several times publicly challenged by surgical friends, and as is well known to all, during the last ten years what is named exploratory laparotomy has very definitely gained in professional appreciation. It ought, perhaps, to have been stated that just before my first paper (1858) was written, I had received an impressive lesson from the recovery of a patient, in whom I had myself much wished to open the abdomen and had been deterred only by the representations of my colleagues that she would certainly die on the table if I did.

As I purpose on the present occasion to review the subject by the aid of the light which modern experience has thrown upon it, and as one result of this examination will be a more confident recommendation of abdominal taxis than I have

ever previously given, it may be well that I should first briefly describe the details of that procedure.

The first point in abdominal taxis is the full use of an anæsthetic, so as to obliterate all muscular resistance. Next (the bowels and bladder being supposed to be empty) the surgeon will forcibly and repeatedly knead the abdomen, pressing its contents vigorously upwards, downwards, and from side to side. The patient is now to be turned on his abdomen, and in this position to be held up by four strong men, and shaken backwards and forwards. This done, the trunk is to be held feet uppermost, and shaking again practised directly upwards and downwards. Whilst in this inverted position copious enemata are to be given. The whole proceedings are to be carried out in a bonâ-fide and energetic manner. It is not to be the name of taxis but the reality, and great patience and perseverance are to be exercised. The inversion of the body, and succussion in this position, is on no account to be omitted, for it is possibly the most important of all. I do not think that I ever spend less than half or three-quarters of an hour in the procedure.

There have been some curious misapprehensions as to abdominal taxis and its objects. Thus I find one surgeon speaks of using it in order to "break down adhesions"; another alludes to it as "massage," and several mention it with a kind of incredulity which I cannot but think springs from ignorance of its details. I make appeal to the well-known facts as to the looseness of many bands, the large size of many apertures, the slight character of many twists, the smallness of the strangulated loop in many cases, when I ask whether it is not very probable that measures such as I have described, if adopted before swelling has occurred or adhesions formed, may often effect replacement. They are such as would compel very considerable movement of the abdominal contents. In many cases on record strangulations of these kinds have been reduced at an operation, or after death, with surprising ease. It may also be remembered that in the olden days strangulated herniæ were not unfrequently reduced by succussion, aided sometimes, but not always, by inversion of the body. To make the intestines

drag upwards by their weight is, I contend, a very likely means of effecting the replacement of a protrusion which is not very tightly strangulated. Jactitation may be effectual even without inversion, and in cases in which the constriction is presumably fairly tight. I well remember many years ago seeing a woman in St. Thomas's Hospital, in whom this had occurred. Mr. South had visited her at her home at Blackheath for a strangulated femoral hernia, and failing in his attempts at reduction had sent her up to the hospital for operation. The shaking to which she was subjected on her journey reduced the hernia, and when she got to the hospital she was well. Surely such a fact should encourage us to the patient use of the much more methodical and efficient plan by inversion in cases in which the strangulation is probably not nearly so tight, and the alternative treatment far more dangerous.

It is to be admitted, respecting abdominal taxis, that it is a troublesome and somewhat undignified procedure, affording no scope for the surgical skill which a laparotomy requires. If, however, it can be shown to be effectual, no conscientious surgeon will allow himself to neglect it because it is disagreeable.

Now, inasmuch as successful cases allow of no dissection, it is obviously impossible to afford conclusive proofs that internal strangulations are ever reduced. A probability is all that can be offered. Before proceeding to relate cases, I will again mention that in many cases in which patients die with internal strangulation by bands, and the condition is placed beyond dispute by the autopsy, there is a history of similar attacks having occurred, and having been recovered from. It is fair to assume that in some at least of these the recovery was by spontaneous reduction. If reduction can take place, and does so frequently, without aid by the taxis, we are much helped to belief in the possible efficacy of the latter.

I once attended, with Dr. Powell of the City Road, a young gentleman who died with acute obstruction, and in whom we proved by post-mortem that the small intestine was strangulated by a diverticulum. I saw him on that occasion only in the very last stage of an acute illness. There was a history that I had seen him two or three years before for a similar

attack, from which he had wholly recovered. I believe that he had also come well through a previous one, in which I was not consulted. It was the confidence induced by these previous recoveries which led to the delay in the last illness.

As examples of successful taxis in acute intestinal obstruction, I venture to mention the following cases. Most of them have been already published, but I cannot afford to leave them out of memory. I shall, however, be very brief.

CASE I.—I visited at one of the City hotels a commercial traveller, in consultation with a hospital colleague and the family attendant. My colleague had urged the immediate necessity for an abdominal exploration, and it was in consequence of this advice that I was consulted. It was an acute abdominal obstruction of three days' standing, and all ordinary measures, enemata, &c., had been well used. The lower bowel was quite empty, and there was distension, with urgent sickness. I suggested the desirability of trying abdominal taxis before doing laparotomy, it being quite understood that my colleague was to have his turn if I failed. We were able to obtain the help of two powerful policemen, and with their aid we shook the patient in various positions. We also placed him head downwards, and in that position administered enemata. Nothing occurred to denote success whilst we were in the house, but in less than an hour afterwards the bowels acted. Recovery ensued, and the gentleman is, I believe, now five and twenty years later, still living.

CASE II.—This is a much more recent one. I mention it out of order because it much resembles the preceding one. A gentleman of about 30 was seized, after running downstairs, by a sudden and acute pain in the abdomen. It was so severe as to make him feel faint, and he was obliged at once to go to bed. He had much pain and sickness. He was attended by his own surgeon, and by Dr. Pye-Smith, the latter of whom had remained with him the whole night previous to my visit. Constipation, in spite of the usual measures, had lasted three days when I saw the patient, and his breath had a disgustingly stercoraceous odour. The lower bowel was quite empty. The case was not so urgent as the preceding one, for when I saw him there was no sickness. It was, however, sufficiently

alarming, and that there was mechanical obstruction there could not be any doubt. We put the patient under an anæsthetic, and then gave an enema, which returned quite free from fæces. We then proceeded in the usual manner. No encouragement was obtained until after long manipulation. We finally placed him head downwards, and tried vertical succussion. After this had been done a few times there was an escape of fæcal flatus from the anus. We placed the patient in bed, and within ten minutes the rectum was full of fluid fæces. I have no doubt from the symptoms, and the kind of fæces which came down, that the obstruction in this instance was in the colon. I have equally little doubt that it was something of the nature of a band or twist. The patient recovered, and has not had any other attack.

CASE III.—I attended, with Dr. Brodie Sewell and Dr. Crosby, a gentleman who all but died with symptoms of acute obstruction. Our first efforts at taxis did not produce any result, and from day to day the propriety of opening the abdomen was discussed, and I had much difficulty in resisting it. The patient recovered perfectly under the persevering use of enemata, but as several days had elapsed since the last use of manipulation under an anæsthetic, I am not entitled to claim it as a case of abdominal taxis.

CASE IV.—Some years ago I was one night called to the London Hospital to an urgent case of acute obstruction, which had just been transferred from the medical side. I did not operate, but spent an hour or more in abdominal taxis, inverting the body, &c., with the result that the bowels acted a few hours afterwards. In connection with this case I may record my experience during twenty years of surgery to the London Hospital, that I never, so far as my memory serves me, encountered a case in which the post-mortem made me regret that I had not opened the abdomen. By this I mean that I never had a case of strangulation by a band or other means which would have been susceptible of definite relief by operation. I speak only of my own patients. My practice always was the use of anæsthetics, manipulation and enemata. Colotomy was done when indicated; but I never opened the abdomen but once, and that for intussusception.

I had two cases of absolutely complete reductions *en masse* of inguinal herniæ, a condition for which laparotomy has recently been practised, but in both of these I succeeded from the inguinal canal. If I were to make similar assertions respecting my experience in private practice, I should have to qualify them much more, for in three fatal cases the post-mortem showed strangulation by bands. In all these I had refused to operate, but at the stage at which I saw the patient I do not think that in any one would laparotomy have been successful, whilst in none had I had the opportunity for trying abdominal taxis in an early stage.

Before proceeding further with the citation of facts, I will offer the following suggestions as rules of treatment :

MEMORANDA AS TO DETAILS OF TREATMENT.

In all cases in which intestinal obstruction is recognized, whether severe or mild, one of the first measures adopted should be the use of an anæsthetic. Under the full influence of ether intestinal spasm will be relaxed, and the passage of scybalæ, gall stones or other impediments favoured.

Whilst the patient is under the anæsthetic the surgeon should make a careful examination of the abdomen, with a view to diagnosis. He should also use enemata, and practice abdominal taxis in full detail.

An accurate diagnosis of the cause of obstruction is not in four out of five cases possible, and the merit of early use of anæsthetics and abdominal taxis is that whilst eminently adapted to the relief of many, it is hardly likely to be really prejudicial to any. The only cases in which the surgeon is in the least likely to regret having employed it are cases in which peritonitis simulates obstruction.

If under the use of the anæsthetic the surgeon has neither been able to relieve the symptoms nor to make a diagnosis, he will now do well, excepting in the most severe cases, to wait a while, and enforcing a starvation regimen, note the development of symptoms.

If the symptoms on recovery from anæsthesia and taxis are severe, if there is urgent vomiting and much pain, then it may be well to lose no time in doing an exploration-laparotomy.

In many cases if anæsthetics be used before distension of the abdomen has taken place, the discovery of a sausage-like swelling may make the diagnosis of intussusception clear, or of an indurated mass that of a malignant stricture, or an impacted gall stone may have been felt, or local swelling may have helped to the recognition of abscess (typhilitis or otherwise). In each of these cases the diagnosis will suggest the suitable treatment.

If an intussusception, recognized in a child under one year of age, the prospect of recovery after operation is so small that it will be better to rely upon repeated and patient efforts at the taxis by enemata and inversion. If, however, the child be older, and especially if the intussusception be long and presenting at the anus, then an operation will offer the best chance of relief.

If the history of the case, or the discoveries is made under the anæsthetic, point strongly to plugging by a gall stone, then belladonna should be freely given, and if there is much pain the long-continued use of anæsthetics may be tried. Very systematic attempts should be made under anæsthetics to get enemata to pass the ileo-cæcal valve. This clearly is the most rational method by which to facilitate the slipping of the calculus. If the distal part of the gut could be distended with fluid, the stone would be almost certain to move onwards when such fluid escaped. Under no circumstances should an operation be done, for however urgent the condition may seem the probability is great that under these measures recovery will ensue.

If the diagnosis be a malignant stricture colotomy should be attempted, and it will usually be wise to prefer the right side.

Distension of the cæcum and fulness of the loins, one or both, are valuable symptoms as indicating the need for colotomy. It must be remembered that distension of the cæcum is apt to occur in all cases of colonic impediment, without regard to its precise place or degree of completeness. It is a very valuable symptom of stricture.

If under the anæsthetic a tumour, presumably an abscess, have been found in either iliac region, then an exploration should be made from the outer side. The error, which has

been several times committed of late, of opening a post-peritoneal abscess through the peritoneal cavity should be carefully avoided.

It may be that the examination under the anæsthetic has neither relieved the constipation nor thrown any light upon its cause, and that the symptoms recur afterwards much as before. If the case is not very urgent the surgeon may now wait a while, and he must carefully again go over the history and note the development of the symptoms. Tenderness, absence of peristalsis, and a smooth, firm, barrel-like abdomen, suggest peritonitis, and it may be well to incise and wash out the abdomen. Slow increase of the abdomen, without tenderness, and with peristalsis, especially in an aged patient, point to stricture and lumbar colotomy. An irregular course, protracted symptoms, and the history of former attacks, in a young or middle-aged patient, point to obstruction by adhesions.

In cases which have persisted long, and in which diagnosis remains in doubt, the surgeon has to choose between several plans of treatment as to the relative superiority of any one of which it is impossible at present to speak with confidence.

1. The rest, opium and starvation plan (what has been called Sydenham's plan) recently advocated by Mr. Thomas. It consists chiefly in abstinence from all interference, and has some negative advantages.

2. Entire abstinence from mouth feeding, but free use of nutritive enemata.

3. Repeated recourse to abdominal taxis with large enemata.

I append the following cases, quoted from various sources, as illustrations of various events as regards the symptoms and treatment of cases of obstruction. Some pains have been taken to display each case in such a manner that its lesson may be easily caught, and in order to this result the "space-for-time method" has been adopted. Each day occupies the same space. To each case I have appended my own comment or criticism, written I trust, when I felt myself obliged to differ from the authors, in no ungenerous spirit.

CASE V.—*Study of Symptoms in a typical case of Twist (volvulus), the patient having been in the Hospital at the time of the beginning of symptoms (Clinical Society's Transactions, vol. vi. Mr. Callender).*

A soldier, aged 46, in good health, who was in bed in the Hospital, after removal of a fatty tumour.

DATE.	DAY OF DISEASE.	DETAILS.
Oct. 28	1	Two days after the operation he complained of pain in back and abdomen. He was already confined to his bed in the hospital.
29	2	Pain subsiding; slightly sick; constipation. It was not thought a serious case.
30	3	Sickness and hiccough. Obstipation continuing.
31	4	Injections and aperients used, but without effect, excepting to increase sickness.
Nov. 1	5	Retchings constant. Vomited matters bile-stained.
2	6	Injections as before returned unaltered. Symptoms persisting.
3	7	The history again carefully examined, but nothing found to throw light on diagnosis. No localized pain or tenderness. Abdomen distended and coils visible.
4	8	More feeble.
5	9	Some fæcal matter obtained by oil injection. Debility increasing.
6	10	Death.

AUTOPSY.—“Three inches above the ileo-cæcal valve a coil of small intestines was twice twisted round a portion of the mesentery, and the canal of the bowel was thus completely obstructed. There were no recent inflammatory changes about this part of the intestines, but from the dense and contracted condition of the bowel where twisted, it must have been for some time narrowed at this point. When I moved aside coils of intestine, which lay in front of the obstruction, more or less adherent amongst themselves by means of old and tough peritoneal bands, and when I endeavoured to, and after some sorting of the parts succeeded, in unrolling the twisted canal, I was glad not to have attempted the operation during the life of the patient, for it would have been impracticable.”

CRITICISM.—*It seems not improbable that in this case some old adhesions favoured the formation of the twist. It may be alleged that an early operation would have found the unravelment not so difficult, but then it must be remembered that the early symptoms were but slightly*

marked. The case was not considered a serious one until several days had passed. It is in order to illustrate the vagueness of the early symptoms that I have quoted the case.

CASE VI.—Nine days' Obstruction without history, and quite sudden onset. Laparotomy. Malignant Stricture of Sigmoid Flexure found. Establishment of an artificial Anus. Recovery. (*Clinical Society's Transactions*, vol. xii. Dr. Church and Mr. Howard Marsh.)

A gipsy woman, aged 40.

DATE.	DAY OF ILLNESS.	DETAILS.
Oct. 7	1	Whilst stooping at field work she was suddenly seized with severe pain, which was followed by sickness and constipation. She had had no trouble with her bowels previously.
8	2	Constipation and sickness in spite of aperients.
9	3	Persisting symptoms.
10	4	"
11	5	" "
12	6	" "
13	7	" "
14	8	" "
15	9	Admitted into St. Bartholomew's on the ninth day of obstipation. Very ill; abdomen distended. Colon especially distended.

TREATMENT AND RESULT.—The abdomen was opened in mid-line. A stricture in sigmoid flexure was easily found. The colon above was opened and stitched

to the wound. She was in a very exhausted condition for four or five days, but afterwards did quite well.

COMMENTARY AND CRITICISM.—*As in the previous case, but in a converse manner, the early symptoms were misleading. They might have led to the suspicion of a twist or band, rather than of malignant stricture. The patient was only 40.*

Colotomy would have been safer, and was indicated by the distension of the colon. In a very similar case at Leeds Mr. Teale, having found the stricture by laparotomy, closed the exploration opening and at once did a lumbar colotomy. In each case the abdominal exploration only added to the danger. It would have been better to have done first a lumbar operation, and if it proved useless then to open the abdomen.

CASE VII.—*Acute Peritonitis with Effusion. Abdomen opened on third day. Supposed Volvulus of Duodenum. Recovery.*

A healthy man (dyspeptic), aged 23, under the care of Mr. Barker.

DATE.	DAY OF ILLNESS.	DETAILS.
Nov. 14	1	Much flatulence and a loose motion, with feeling of sickness. In a few minutes most violent pain in the abdomen. Vomiting soon after the pain began.
15	2	
16	3	Pain and vomiting as before. Seen by Mr. Barker in the afternoon. Abdomen distended and tympanitic, except in flanks.

TREATMENT AND RESULT.—Laparotomy 50 hours from onset. Median incision; odourless gas and much fluid escaped. The intestines were congested, and showed flakes and patches of lymph. The whole length of the bowel was carefully examined, but no band or stricture was found. Mr. Barker believed that he had (without knowing it) unfolded a twist of the jejunum. The patient recovered.

CRITICISM.—*Although a volvulus was suspected, it must be admitted that there is no proof that the case was more than one of acute peritonitis. On the latter supposition, however, no special cause could be assigned. If it were peritonitis only, it is a triumphant result for operation treatment, and washing out of the abdomen. If it were a volvulus, and of such a slight nature that the operator without knowing reduced it, then it is fair to suggest that it was just one of the cases which manipulation and inversion of the body might easily have shaken right, especially if employed in an early stage.*

CASE VIII.—*Gradual development of obstruction-symptoms; without urgent distress. Laparatomy on ninth day of Obstipation. Establishment of a Cæcal Fistula. Recovery, but with relapses of symptoms, necessitating Colotomy (Clinical Society's Transactions, vol. xii. Cayley and Lawson).*

A printer, aged 23, who had suffered more or less from constipation and colic.

DATE.	DAY OF ILLNESS.	DETAILS.
May 29	1	Seized with colic while at work. In the evening had vomiting.
30	2	Obstipation and sickness.
31	3	Obstipation, colic, and vomiting.
June 1	4	The same symptoms, with gradual increase in severity.
2	5	The same. Continued fæcal vomiting.
3	6	Admitted into Middlesex Hospital under Dr. Cayley. Twisting pain and distension; urine free; pulse 108; temp. 99·2°. The bowel would hold two quarts.
4	7	Pulse 100; temp. 98·8°. Increase of distension, but less vomiting.
5	8	Pulse 104; temp. 99°. The vomiting continued at intervals, but the patient was not in much distress. He could still amuse himself by reading.
6	9	Mr. Lawson opened the abdomen in middle line. Intestines distended and red, but free from lymph. Cæcum enormously distended. No cause of constriction found. Cæcum punctured and stitched to wound with very great difficulty. Operation very troublesome.

DATE.	DAY OF ILLNESS.	DETAILS.
June 7	10	Pulse 161 ; temp. 103°.
8	11	Better.
9	12	Improving.
10	13	Improving.
11	14	The bowels acted per anus, and from this date he recovered, but with relapses.

COMMENTARY AND CRITICISM.—Mr. Lawson expresses his opinion that it would be ultimately needful to open the colon. He also adds, in which all will agree, that a right or even a left colotomy would have been the best operation in the first instance. The obstruction was probably in the sigmoid flexure.

The case is a good example of the enormous distension of the cæcum, which sometimes attends obstruction at a great distance. The operation was obviously a very difficult one, and very nearly proved fatal. A right colotomy would have been easy and safe. The case is very like one of my own, in which we found a malignant stricture. In a subsequent report (Vol. xiii. of Clinical Society's Transactions), Mr. Lawson gives the conclusion of the case. The man died about ten months after the operation. The autopsy showed colloid cancer of sigmoid flexure of colon and a stricture at the hepatic flexure. A right colotomy would therefore have been the best operation.

CASE IX.—*Abdominal Obstruction. Twenty-three days' absolute Obstipation. Starvation Treatment, with Opium and Belladonna. Further periods of Obstipation. Bleeding from Bowel. Final recovery after a fifty days' most critical illness* (It is published in the *Liverpool Medico-Chirurgical Journal*, January, 1888).

The subject of the following narrative was a lad of 17, under Dr. Barr's care in private.

DATE.	DAY OF ILLNESS.	DETAILS.
Sept. 24	1	Caught cold, but took a hearty supper afterwards.
25	2	Constipation began after severe griping pain and purging; severe pains in abdomen.
26	3	Persisting and complete obstipation.
27	4	Pain; vomiting; no flatus passed; obstipation complete.
28	5	The same symptoms; temp. 100°. Supposed to be peritonitis.
29	6	Severe pain; legs drawn up; abdomen tense.
30	7	Face pinched; pulse smaller and weak; vomiting and hiccup; abdomen distended.
Oct. 1	8	Incessant hiccup; thought to be dying; skin cold and clammy; vomiting offensive.
2	9	Still very ill; pulse 130; vomiting and hiccup.
3	10	Dr. Wallace saw him; pulse 130.
4	11	Much the same
5	12	" "
6	13	" "
7	14	" "
8	15	" "
9	16	Remaining in a most critical condition.
10	17	" "
11	18	" "
12	19	" "
13	20	" "
14	21	Is much emaciated, and has persisting symptoms.
15	22	" "

DATE.	DAY OF ILLNESS.	DETAILS.
Oct. 16	23	Is much emaciated, and has persisting symptoms.
17	24	" "
18	25	A liquid motion, the first since beginning of illness.
19	26	Flatus, but no fæces.
20	27	Gripping pains ; peristalsis visible.
21	28	" "
22	29	" "
23	30	Large semi-solid motion.
24	31	Constipation recurred.
25	32	" "
26	33	A large semi-solid motion ; nothing found in it.
27	34	
28	35	A semi-solid motion, with large quantity of fluid blood. Collapse.
29	36	Extremely weak.
30	37	He remained during the next ten days very weak, but improving.
31	38	
Nov. 1	39	Gentle massage treatment. Hypodermics still needed once a day.
2	40	
3	41	
4	42	
5	43	
6	44	
7	45	
8	46	A natural motion of large size.
9	47	Improving.
10	48	"
11	49	After this steady recovery. Regained perfect health, and is quite well at the present time.

DR. BARR'S DIAGNOSIS.—Dr. Barr has kindly written for me the following note as to his final diagnosis: "I may say that I looked upon the case as one of

intussusception, though this diagnosis might be questioned, as there was never any slough discovered in the motions. Anyhow the obstruction was complete, and was not due to hardened fæces. The obstruction was low down, but not in the colon, as it was not involved in the abdominal distension, nor in the violent peristalsis which occurred in large rolls across the whole front of the abdomen. I feel still inclined to look upon the case as one of intussusception about the ileo-cæcal valve."

CRITICISM.—*I have reproduced this remarkable case because it seems to illustrate some points of great interest. It may be said to be almost impossible even with its completed facts before us to form any satisfactory diagnosis as to the cause of the long-continued symptoms of obstruction. This difficulty was present at all stages. In the early stage the symptoms would have justified an operation whether the diagnosis were peritonitis, strangulation by band, or intussusception. An operation then would probably have much shortened the case, but in which direction may be open to doubt. That severe symptoms in the onset—those of "acute obstruction"—are not always followed by death when operative treatment is avoided the case proves. The patient's life was saved under the most patient abstention from all heroic measures. It must be admitted, however, that the lad was repeatedly, and during long periods, in the most urgent peril. The diagnosis suggested by Dr. Barr seems, on the whole, the most probable, though not unattended by difficulties. No bloody mucus was voided during the early stage, and no portion of intestines was detected in the later ones. That it was not one of peritonitis only, the existence of visible peristalsis at a late stage may be held to prove. The advocates of early exploratory operations and those who condemn them have almost equal right to claim the case as supporting their views. It was probably at all periods after the first week very wise to abstain. Only during the earliest period is it likely that the abdomen could have been opened with any chance of success.*

THREE CASES OF A SEVERE AND AGGRESSIVE CACHEXIA IN ASSOCIATION WITH SCAR- LEAVING ERUPTIONS ON THE EXTREMITIES.

Two of the three cases which I have to relate under the above title have ended fatally. The third is a far less severe case, but usefully illustrates an early stage of the malady.

The cases of Mrs. R—— (Case 1) and Miss G—— (Case 2) present many features in common. In each the patient was a woman, and undoubtedly of very feeble circulation from birth. In neither of them, however, did the disease of the skin, which was one of the most prominent features of the last illness, begin until adult life. Miss G—— was 22, and Mrs. R—— was 31. In both patients the hands, feet, and face were the parts affected, exactly as in Kaposi's disease, and in both the influence of local irritants and of cold in inducing the symptoms was definite. In this latter feature they approached, indeed probably partook of, the nature of Raynaud's malady. In Miss G—— the feet were very severely affected, whilst in Mrs. R—— they suffered but very little. The conditions in both differed from chilblains, in that there was a diffuse congestion of the skin with a tendency to local ulcerations. The coincident failure in health and strength which was very marked in both cases was a feature which placed them at a great distance from ordinary chilblains. In Miss G—— stigmata and pigmented patches were produced exactly as in Kaposi's disease, whilst in Mrs. R—— an earthy pallor of the skin of the face was the chief symptom. She had no stigmata, but on the cheeks there were patches which were deeply pigmented. In Mrs. R—— there were some slightly marked erythematous patches on one thigh, which ended in the production of scars without ulcers.

Those who hold that it is always possible to assign diseases to definite categories, and always a duty to attempt it, may perhaps assume a critical attitude when I say that I believe that these cases were examples of mixed causation, and they partook of the essential nature of lupus erythematosus, Raynaud's disease, and Kaposi's disease. A derangement of the forces of the circulation, giving liability to general chilliness and especially to bloodlessness of the extremities, is of the very essence of Raynaud's malady. A congenital structural peculiarity of the structure of the skin of the extremities, making these parts liable to inflame from exposure, to produce stigmata, pigment patches and ulcerations, is the basis of Kaposi's malady. There is no reason whatever why Raynaud's vascular susceptibility should not chance to occur to a patient in whom a certain degree of this structural peculiarity had from the first been present. Lastly, in lupus erythematosus we have an infectious form of inflammation of the skin prone to attack the face and hands of feeble persons and attended by risk of attacks of erysipelas. It is quite possible that this type of inflammation might be engrafted on the conditions just specified. In other words, the partnership which I suggest is a very possible one. There is nothing specific in any one of the maladies named, and no reason whatever why they should not mix together and produce a hybrid, or, rather, a mongrel result. Should the combination now described be found to be a frequent and definite one, it may then become suitable to devise a special name for it. For the present, however, the facts are not sufficiently numerous, nor the parallelism of the cases sufficiently close, to make such a course desirable. Some further references to the points just adverted to will occur as I proceed to narrate the cases.

CASE I.—*A Fatal Illness extending over Three Years and attended by General Rheumatism; Great Chilliness; Anæmia of the Extremities; Pigmentation; Gangrene of the Skin in Patches; Loss of Hair; Dry Mouth; High Temperatures, &c., &c.*

I was first consulted by Mrs. R—— in September, 1886, when

she was brought to me by Dr. Johnstone of Melton Mowbray. She appeared to me to be the subject of crippling rheumatism, walking with both hips stiff, and with many of the small joints of the fingers more or less affected. She was extremely cachectic and feeble, and I was told that she had suffered from menorrhagia. Her pallid aspect and nauseous odour suggested uterine cancer. Her age was thirty-five. She had no children. An uncle had suffered severely from gout, but not her father. She told me that she had never been laid up in bed by rheumatism. It had begun insidiously in November of 1882, and her right forefinger had been first affected. In June of that year she had had a fall from her carriage, which she seemed to think had brought out the chronic rheumatism. I ordered her quinine and nuxvomica, and a dose of guaiacum every night. I saw her again about a month later, when she appeared decidedly better. Both these consultations were, from circumstances over which I had no control, much hurried. After the second I did not see her again for four months. On January 3, 1887, she came to me again and drew my attention to other matters. The skin of her hand, fore-arms, face, and feet, had for the last six weeks been affected by little ulcerations which occurred in groups, and left conspicuous white scars. Many of her nails were inflamed and suppurating at their roots. Her fingers were thin and wasted, especially at their tips. Several of the fingers presented ulcerations of considerable extent, and on the middle finger of the right hand there was an irregular slough, as big as a sixpence, which was rather deep. Her fingers were dusky and mottled, and I was half inclined to think that we had to deal with a case of diffuse morphea.* This suspicion was in part confirmed by the

* The following extract from a letter by the patient's husband, dated December 24, 1886, describes the condition of the fingers. I did not see them then:—"I am sorry to have to write to you again, but one of my wife's fingers is so very bad that I should like to hear your opinion about it, or if my description is not sufficiently clear I would bring her up to town to see you again. It is the third finger of the right hand, on which there was a mark caused by the wool in knitting, which had a scared appearance; you looked at it when she saw you last. Nearly three weeks ago the finger became very inflamed and irritable, and yellow places came in it; the second joint also was very tender to

state of her face, for the lips were more or less stiff and wooden, exposing the teeth. It was impossible, however, to prove any parchment condition in the skin of the face. Her hair had almost wholly fallen off, and there were some small ulcers in the middle of the top of the head. Her tongue was red, smooth, beefy, and dry. On the date of which the above notes were taken Mrs. R—— had come up from the country. She seemed so weak that I feared for her life if she returned, and advised her to seek admission in a Home and go to bed at once. This she did, and her condition during the next night was so urgent as to cause great anxiety.

My next notes were written on *February 5th*. Mrs. R—— has now been for a month at Mrs. Mann's Home. The chief treatment has been by the administration of small doses of opium in combination with tonics. This has had the effect of making her more comfortable, and has had no material inconvenience except constipation. Her temperatures have never fallen below 100°, and have usually been 101°. Her tongue has always been red and clean, and, with her lips, quite dry. She has taken a large quantity of fluid food. Her face is always earthy like that of a corpse, and if she closes her eyes she looks exactly as if dead. She has slowly lost flesh, and is now very thin. On one occasion I left off the opiate, but she became so restless and low that we were obliged to resume it. The fingers have slowly improved. She tells me that if she gets out of bed both fingers and toes ache severely. It has been very difficult to prevent a bed sore on the sacrum. Patches of erythema are prone to show themselves wherever there is the slightest pressure, and in the middle of these minute streaks of skin become tallowy and then shrivel, leaving a scar. This has occurred over both outer malleoli, and in front of both tibiae. These patches are, however, by no means restricted to parts irritated by pressure. On the lower part of the abdomen and over the fronts of both thighs erythematous patches covered with small lichen spots have the touch and much swollen. It had been poulticed for some time, but now she only puts lint and cream upon it, as she cannot bear that it should be exposed at all to the air, and one place is very deep. The second finger on the same hand looks as if it were going in the same way. The whole finger looks so peculiar that Mrs. R—— consulted a doctor in Durham."

formed. These patches have slowly enlarged, and have left as they faded a number of small scattered scars. Similar patches have been present behind the thighs. They show some tendency to spread at their edges like lupus erythematosus, and my impression is that they are of that nature. Inside the ears, also, pustules have formed, and one in the left has been attended by a small slough. On many parts of her skin Mrs. R—— is now dark enough to suggest a suspicion that the supra-renals may be diseased.

At this date Mr. R—— gave me the following additional facts as to his wife's health. At the time of their marriage she was in fair health but very pale, and liable to suffer extremely at her monthly periods. She was a younger child of a large family, and her brothers and sisters are healthy. Soon after the rheumatism began, or possibly before, she used to suffer from dying of the hands. All her fingers would on the slightest exposure become white and cold and subsequently livid. Her feet also were often "like ice." Later on her fingers seemed tender, and she would sometimes cry out when taken by the hand. About a year ago, a more definite proof of the difficulty with which nutrition was maintained occurred in the fact that when her worsted in knitting played over one finger a dent was formed. There was no ulceration, but a depression almost like a scar. Another similar shrivelling of a patch of skin occurred on one forefinger, where the handle of the coffee-pot had rested. A journey which Mrs. R—— took to Matlock Baths was an unfortunate one. She failed in health there, and the eruption on the hands began to show itself. It was first supposed to be due to bites of gnats. Around the gnat-bites little red rings formed, and scars were produced. After this there was inflammation around the root of the nails, then what she called "corns" on some of the fingers. On some parts it was thought that scars resulted without any ulceration having preceded them. She had great pain in the fingers, and her strength rapidly failed. After the fingers inflamed the tendency to die away ceased. The place where a large slough formed was believed to be the same as that which had been irritated by the worsted.

The following notes were written *March 21, 1887.* "Mrs.

R—— is to leave London in a day or two. She has been in bed at Mrs. Mann's for nearly three months. Under the influence of small doses of opium she has made steady improvement. Once when we tried to leave it off, on account of sickness, she became restless, faint, and very feeble. *Nepenthe*, in twenty minim doses three times a day, has suited better than the liquor opii. Although she has gained a little in strength she remains still very weak, and is emaciated to an extreme degree. All her sores have healed, and her fingers are now sound. The face and body generally are deeply pigmented, the skin generally being of a sallow brown tint, with spots of much deeper colour in many places. The rheumatic stiffening of her hips is better. Her tongue is always beefy, and perfectly clean, but it is not so dry as it used to be. She eats and drinks well. The scalp hair is extremely thin and short, and scanty to such an extent that she is almost bald. In reviewing her case the following points seem worthy of special attention. The disease has differed very definitely in some features from Raynaud's disease, and has in others come much nearer to lupus erythematosus. Thus the sloughs on the fingers have never been exactly at the tips, but at the sides of the digits, near to their ends. The sloughs in the ears were inside the concha, a part not exposed to injury and not liable to chilblain. The large patches of lichenoid erythema have been on the abdomen, thighs, arms, face, and scalp, regions not specially exposed to alterations in blood supply. The patches which have been gangrenous have always been very painful during the separation of the slough. They have occurred on the fingers chiefly, but once or twice on the ears, and once on a toe.

“The patches which I have described as lichenoid erythema have been very large in size, spreading at their edges, but in places not well defined. They have occurred on the face and head, on the arms, abdomen, and thighs. These patches were very slow in their changes. At first slightly congested, much pigmented, and rough all over with dry lichenoid spots, they became in the course of six weeks or a couple of months gradually free from congestion and less rough, but still darker in colour, and showing here and there

small scars. A few of the scars were abruptly margined, and have been preceded by definite loss of tissue, but others were of a sub-epidermal character, and simply white without unevenness of surface. I carefully watched the formation of this kind of scar on several parts, especially on one upper eyelid, and over one external malleolus. A small area of skin, not perhaps bigger than a split pea, became quite white and like tallow. It looked as if it were going to slough, but no sloughing took place, and after a few weeks' duration a silvery-white scar was all that remained. Some of these little spots appeared to have resulted from local pressure or irritation, being a sort of microscopic bedsores, but others, as for instance one on the eyelid, did not admit of any such explanation.

"The morbid processes have differed from those of lupus erythematosus in that they have tended to a tolerably rapid spontaneous subsidence. Thus the whole of the scalp and face have got quite well, being left simply mottled by pigment stains, and somewhat marbled by scars. Although slow in its progress, in no place has the disease shown a tendency to persist indefinitely. I may add that I have never seen localized gangrene as a part of the process of lupus erythematosus. We must bear in mind that it is quite possible that our patient is the subject of disease of the supra-renal capsules, and that this may account for the severe constitutional symptoms and the great tendency to pigment stain."

After Mrs. R—— returned to Melton I did not see her again. She was carefully attended by her own medical man, and was seen by Dr. Newman, of Stamford. On April 5, 1887, I heard from her husband that she was going on fairly well, he thought, and gaining a little in flesh and strength. Most of the ulcers were healed, and the temperatures were normal. A month or two later she was taken to West Malvern, where she was attended by Dr. William Murphy. After a few weeks' stay at this place she became suddenly much more weak. She died on July 10th. She had suffered during the last day or two from severe pain over the liver, and Dr. Murphy recognized "a distinct swelling in that region." She had also a considerable quantity of albumen in the urine, and some

bronchitis. I obtained the husband's consent to an autopsy, and Dr. Murphy and Dr. Weir had kindly undertaken to conduct it. We were baffled, however, at the last moment by the resolute refusal of the lodging-house keeper to permit it in his house. Thus the opportunity for determining whether or not the supra-renal capsules were affected or whether any other form of abdominal disease was present was most unfortunately lost. The great debility which had attended the last six months of life, and the rather sudden failure of strength which immediately preceded death were very like what often occur in Addison's disease. If, however, the malady were of that nature, it was clearly a complicated case, for I am not aware that the tendency to inflammation and gangrenous implication of skin has ever been noted in connection with it.

CASE II.—*Simulation of Kaposi's Disease, and of Lupus Erythematosus, &c.; Extreme Emaciation and Debility; Dry Mouth; Great Chilliness. Death from Erysipelas.*

Miss G—— was put under my care in June, 1886, suffering from a most peculiar condition of her skin. She was extremely emaciated, her lips were quite dry, and were somewhat cracked, and the whole of her mouth was dry. This dryness of mouth and lips had been present for about two months, and obliged her to take some fluid every few minutes or so. The state of her face much reminded me of Kaposi's disease, the skin being somewhat tight and covered with stigmata and spots of pigment. Some of the pigment spots looked like little moles, but she assured me that they had all come recently. When I saw her there was no saliva whatever in the mouth, but the tongue was not actually dry, nor were the insides of cheeks so dry as in the case of Mrs. R——. Her palate was of a yellowish white colour, and looked like that of a corpse. Her temperature at the time of her visit to me was 100°. Her bowels were reported to be somewhat costive, and she said that she was always feverish through the night and slept badly.

In inquiring as to the antecedents of her illness, I learned that Miss G—— had formerly enjoyed good health. She had

been very active, and had never had a day's illness until the present ailments set in about a year ago. She had always, however, had "a miserable circulation," and hardly ever known what it was to have her feet or hands warm; when cold weather set in she had always suffered from chilblains. Her expression was "that she never felt fatigued, but was always bitterly cold." Such was her condition of health, when in the spring of 1885, she began to have spots on the face. Her face, nose, and ears were, as she described it, "of a red glow." She consulted a distinguished specialist, who called it eczema, but after several months of treatment did it no good. In July, of the same year, she had what was believed to be spontaneous ptyalism. As her teeth became loose it may, however, be doubted whether mercury had not been inadvertently given. In the autumn of the same year she went to Switzerland, and came back a little better. She spent her winter at Sydenham, under the care of Dr. Waller, by whom she was afterwards referred to me. Six weeks before coming to me she had had a more acute illness, which had been attended by constant vomiting, and subsequently by jaundice (possibly erysipelas). She was a lover of hot weather.

After the date to which the above notes refer I saw Miss G—— once or twice, during the autumn of 1886. Under the use of tonics and some local measures she got somewhat better, but at the date of her last visit to me (Oct. 17th) the skin of her feet, hands, and face was still in the condition described. Her toes, fingers, and ears showed superficial ulcerations on many parts, and the skin was everywhere more or less glossy and tight. There were no definitely margined patches of erythema, but numerous stigmata were scattered over the affected surfaces. The skin of her body and of all parts excepting those mentioned was quite healthy. I recommended that she should on no account winter in England, and arrangements were made for her to go to Alassio in the Riviera. She set out late in November. Severe discomforts were encountered on the journey from changes of carriage and exposure to cold during bad weather. Her feet became inflamed and very painful, and when she reached Alassio, on December 3rd, she was very ill. A week later she

had a temperature of 105°, and a pulse of 180. In spite of a little improvement subsequently she died on December 16th. She had been more or less delirious for several days, and during the last three days there had been jaundice. The inflammation of her feet had been diagnosed as erysipelas.*

It might seem that in this case we have a sort of connecting link between Kaposi's disease and lupus erythematosus and diffuse morphœa. From the former it differed in that the inflammation of the feet, face, and hands did not begin in early childhood; and that it was preceded by conditions of very definite defect of circulation. As regards the other features assumed by the disease they were exactly those of that malady, and a similar statement is true as regards the parts affected. I do not know that a tendency to erysipelas has been specially noticed in Kaposi's disease. It is well known to be a frequent cause of death in lupus erythematosus, especially in those forms in which the disease affects large areas on the face and scalp, and involves the hands also. It is very rare for lupus erythematosus to attack the feet, which was the case in this instance.

CASE III.—*Debility and extreme Chilliness in association with Eruption in the Ears and Hands.*

The case which I am about to append is, I feel sure, of the same essential nature as the two preceding ones, though in a far milder form, and not as yet in any way threatening to end fatally. We have, however, as features common to the three, extreme chillings, great feeling of weakness and an erythematous, scar-leaving eruption, which affects the ears, hands, and finger nails.

Mrs. G——, aged 36, of dark complexion, thin, and very pale, came under my care for the first time on February 2, 1887. Her trouble was “these places on my hands which come every winter.” She showed a number of little

* Dr. Beatty, of Alassio, under whose care she died, was kind enough to send me the particulars of her last weeks of illness. There could be little doubt that the cause of death was exhaustion from erysipelas, with possibly affection of the meninges of brain. She died comatose.

isolated erythematous discs on the fingers and backs of hands. Some had faded and left ill-marked scars. In the concha of each ear there was also an erythematous peeling patch. She had no eruption on the face. She told me that she had had the patches on the hands and ears every winter for three years, and that on the first occasion the feet were also affected. Although they came only in winter she did not incline to associate them specially with cold, but rather with residence in London. She always got rid of them, she said, when the time for going into the country came. In London she always felt weak and ill, and lost appetite. She had never in her life had chilblains. During the whole of the three years that she had been liable to the eruption, and for some time previously she had been out of health in the direction of constant lassitude and strengthlessness. Although she had been married ten years her first and only child had been born only eighteen months ago. She did not suckle it, and had been quite regular since the confinement. She suffered much from indigestion, and was usually sleepy and dull after meals. Her feet were cold occasionally, but there was no proof of any definite feebleness of circulation. She was both rheumatic and neuralgic, but knew of no history of gout in the family. She was accustomed to take a little claret.

Dermatologists will probably be inclined to claim this case—marked by erythematous scar leaving discs in the hands and ears—as one of lupus erythematosus. As such I am myself inclined to regard it, but it is certainly very exceptional in that malady for the face to escape, and also for the patches to wholly disappear in summer. I wish also particularly to emphasize the fact that the eruption appeared to connote a definite and progressive failure in health.

Mrs. G—— came to me again about two years after the above notes were taken. She was still liable during cold weather to the occurrence of the erythematous discs on her hands, and showed me a considerable number of them. They were, she said, persistent through the whole winter and, unlike chilblains, some of them occurred on the palmar surface of the fingers. They were abruptly margined, about

a line in elevation, and presented flat scaly spots, which peeled. Some were about the size of peas, and a few nearly as large as shillings. They occurred on the hands only. There was no general duskiness of the fingers, nor any change in the condition of the nails. Mrs. G—— told me that she had never been in good health since I had last seen her, and especially that she was never able to keep warm. She had a very feeble pulse and was thin and pale. She was liable to diarrhoea, and suffered much from neuralgia, especially on the top of the head. She came to me on this second occasion, not on account of the hands, but for an inflamed mouth. This was of only a few days' duration, and probably accidental. I found the mucous membrane over Wharton's ducts swollen and cedematous. She said that she almost constantly felt chilly, but that if she went near the fire it made her skin itch. She had spent the winter of the year before in the Riviera, but had been ill all the time with severe catarrh, which settled on her chest. Mrs. G——'s own expression was, "I am always chilly, and in winter dreadfully cold. I often feel as if I had not any blood in me, cold all through me." Her condition did not appear to be influenced in any way by the menstrual function, for she was quite regular, and not more chilly during the menstrual period than at other times. Having been informed that she had lived for several years in a house with a north aspect only, I strongly advised that she should make a change and secure sunny rooms. She was about to leave for the south of England when I last saw her.

I must leave these remarkable cases, with such comments as are already made, to tell their own story. At some future time, and with the help of other fragments of evidence, I shall hope to recur to the subject. So far as I can judge, the conditions described were not those of any new disease, but the consequences of a very exceptional partnership of morbid causes.

DISEASES OF THE EYE.

No. I.—*On Increase of Tension in the course of Syphilitic Keratitis.*

IN the course of interstitial keratitis from inherited syphilis, there is now and then increase of tension. I have had to treat three or four cases in which this symptom, together with unusually severe pain and intolerance of light, has occasioned great anxiety as to the safety of the eyes. I have usually thought it best to perform iridectomy. In all cases in which I have done this operation the relief has been immediate and the after-progress most satisfactory. The operation, however, has its drawbacks, for although the cornea may for a long time remain more or less opaque, it usually in the end clears completely, and then a disfiguring coloboma is exposed. The fear lest the cornea might, owing to the unusual severity of the case, not clear well, has hitherto led me to do the iridectomy downwards. All the cases of which I am speaking occurred some years ago, and before the introduction of eserine. Two suggestions have recently come into my mind. First, is it possible that the increase of tension, which constituted the alarming feature in these cases, was due to the over-use of atropine? and, secondly, would it not be well in any future case, instead of doing an iridectomy, to try eserine? It is true that in most of these cases there is some iritis, but the plastic stage may perhaps not improbably be passed when the tension commences. At any rate, if in future I should ever be forced to do an iridectomy, I should certainly do it upwards.

No. II.—*Simulation of Retinitis Pigmentosa in a Case of Acquired Syphilis.*

A very peculiar, rare, and important form of choroido-retinitis is sometimes met with as the result of syphilis, in which the

changes appear to be degenerative rather than inflammatory, and in which they are slowly but steadily progressive. In this form the final conditions resemble very closely those of retinitis pigmentosa. There are, however, always some minor features of difference by which the syphilitic simulation of the latter malady may be distinguished from the true disease. These cases are more common after inherited syphilis than after the acquired form; they are, however, now and then encountered after the latter. A very good example of it in connection with acquired disease is the subject of the following narrative. [The notes were written out in 1878.]

Mrs. Anderson, aged 49, is now so nearly blind that she can see to read only 20 Jæger, and not 200 in the distance. She has got much worse during the last year, but her malady has been very slowly aggressive, and it is twelve years since she saw to read or do needle-work easily. Failure of sight in the evening, and a musca before her left eye were her earliest symptoms. The date of the syphilis, to which we attribute her disease, was about two years before her first symptoms. The eyes were not painful, and there was no sudden onset of disease. In the early stages there was much watering of the eyes. She used also at this time to see occasionally "a large globe of light like a half-moon" pass before her eyes, and often a body like a fly without wings. She never had any material pain in the eyes. Although, as I have said, the disease has slowly progressed, it has not been at a uniform rate, but rather by jerks. She thinks that she has sometimes been several years without getting much worse, and then in the course of a few months has experienced decided deterioration. Especially she associates increased failure of sight with an attack of something like rheumatic fever eighteen months ago. Up to that date she had been able, in good daylight, to see to do needle-work, although for long before quite incapable of seeing to thread her needle. The history as regards syphilis is, that fourteen or fifteen years ago she had sores, which were followed by a rash and sore throat. She was quite unaware what her ailment was, and did not consult any surgeon. Two years later she found that her sight had much failed, that the eyes watered, and that she saw

the "globes of light and flies," and under these circumstances she consulted a specialist. It did not appear that her disease had ever been diagnosed, and probably she had not taken specifics, or at any rate not regularly. Once at King's College Hospital, where she applied for a sore tongue, she was asked whether she had not had something else the matter, but she did not understand the question. As additional evidence of her syphilis, I may state that she has several considerable scars on the sides of her tongue, on its dorsum, and at the angles of the mouth. These are all characteristic, and she states that her tongue has repeatedly at different times been very sore. At present it is quite sound, and I may note that there is no general atrophy of papillæ, and no bald patches or leucomata. The condition is that of definite local scars from definite ulcers. Had she been a man and smoked, probably her tongue would have been far worse. As it is, it bears conclusive evidence to the fact that she is syphilitic, and it is of much interest to note that like her eyes, her tongue has experienced repeated relapses of disease, often well for a few months or a year or two, and then again ulcerated.

Such, then, are the facts as regards Mrs. Anderson's ailments, and to them I may add the negative ones that she has never had any indications of cerebral syphilis, and that she has on the whole enjoyed good health. At present she looks well and younger than her real age. She had borne three children before her syphilis, and has had none since. Let me next describe the condition of her eyes. In both eyes the retina is extensively disorganized, with some involvement of the choroid, abundant pigmentation of retina and waxy discs. The state of the discs is exactly like that seen in retinitis pigmentosa; they look as if made of pink wax, are a little elevated, and slightly hazy; the central vessels, both veins and arteries, are very much diminished. All will remember how constant this diminution of the vessels is in the true retinitis pigmentosa. Yet no one of experience would mistake the retinal changes generally for those of the latter malady. Although there are many minute dots and lines of pigment, and many of them more or less like bone corpuscles; yet, in addition to these, there are also many large black masses, such as

we never see in the latter, and, further, in many parts there is proof of choroidal disorganization. The changes in the choroid are far less than in choroiditis disseminata, but they are present. Although the periphery of the fundus is much affected, yet the zonular arrangement of the morbid changes is far less definite than is usual in retinitis pigmentosa. There are a few faint striæ of opacity in the posterior part of the lens. The conditions, although not accurately symmetrical, are very considerable in both eyes. The eyes did not, however, fail together, and for long one was much better than the other.

It will be seen, then, that it is probable that this patient had syphilis and was never treated, that she suffered from syphilitic retinitis within the second year, and that since then slow changes have been in progress, stationary for a time and then again relapsing, which have eventually disorganized the structures concerned. It becomes of importance to ask whether we have other facts in the history of syphilis which correspond with this. I have already said that in the eye itself, and especially in connection with inherited syphilis, we have unfortunately many such. It is by no means uncommon for those who have suffered from keratitis and choroiditis in early life to become almost blind in later years, with slow pigmentary changes in the retina, followed eventually by other derangements in the nutrition of the eyeball. Secondary cataracts sometimes occur, and now and then an attack of glaucoma necessitates the excision of an organ which has for long been useless. These results are, I admit and repeat, less frequent in the acquired form of disease. But the long persistence of morbid changes, not perhaps exactly syphilitic, but still resulting from syphilis, in the first instance, is met with occasionally in other parts. I had not long ago under care a cachectic man, with ulcers in his tongue of many years' duration, and undoubtedly specific. He had made them worse by smoking. It was not, however, his tongue, but his legs, which chiefly interested me. Both his legs were covered with large patches of a very superficial eruption of dusky colour, which left thin scars. It was in reality a serpiginous syphilitic ulceration, but the ulceration process was exceedingly

slight. Now it was twenty years since that man had syphilis, and his legs during the last twelve years had never been well. They had given him but little trouble, and he had had but little treatment, but he tells me that he was temporarily cured under my own care some ten years ago at the Metropolitan Free Hospital. Now substitute legs for choroids, and we have in these two cases almost exact counter-parts of each other. Certain forms of palmar psoriasis, which follow syphilis, and which persist for years offer also very close analogues to our case, in that a local disease of slight severity persists for many years, whilst the patient enjoys good health, and is free from other evidences of active syphilis. The mucous membrane of the tongue, again, is very often the seat of slowly progressive changes, which have their starting-point in syphilis, but which are finally of a degenerative type rather than specific in any active sense. Hence result the conditions of baldness and white patches with thickening, to which the term *ichthyosis* has been somewhat thoughtlessly applied. Making allowance for difference of the tissue involved, the similarity is probably very close between certain cases of chronic disease of the tongue, psoriasis palmaris and progressive choroido-retinitis. We may suitably remember that it is possible that disease of a similar type (that is, equally local, quiet, degenerative and slowly progressive) may attack any part of the nervous system. In the spinal cord it might produce any one of the various forms of paraplegia, and might derange any one of the functions of the cord leaving the others free. It might attack the ganglia of the vaso-motor system, or any one or any pair of them, and produce symptoms of a very peculiar and not easily comprehensible kind. I believe that I have succeeded in making it probable that the little ophthalmic ganglion is not infrequently so attacked and disorganized, and what is true of it is in all probability true of the others. It is clear that we have here a type of syphilitic lesion very different from the common gumma, and also from the results of arterial disease. Without asserting that it does not begin in inflammation (for in all probability it does), or that it is not attended by slight relapses of inflammatory action, I still hold that the term "progressive degenerative changes" may for a time at least

be found very useful to distinguish this group of the results of syphilis from others of a more conspicuously active type. As to the histology of the local changes, we as yet know but little, nor is it very probable that an opportunity will be afforded for examining the tissues in an early stage of the disease. Of this, however, we may feel tolerably sure that there is nothing of the nature of definite gumma at any period, and that iodide of potassium seldom produces any marked benefit. I make this assertion as to the non-results from specific treatment rather from what I have observed in congenital syphilis than in the acquired form, and I would be far from wishing to imply that specifics ought not to be used. A long-continued course of mercury would indeed be well worth trying in all cases, but it is as yet a matter of doubt as to whether by its means an arrest of the downward progress can always be obtained.

I am not able to bring forward many cases so definite and complete as that of Mrs. Anderson, and shall probably have to refer to hers frequently in the future. Before concluding, I may be permitted to draw especial attention to the fact of close similarity to retinitis pigmentosa, as suggesting that although a consequence of syphilis, the local changes have, after all, but little of a specific character about them. Of the causes of true retinitis pigmentosa we know nothing, but it is certain that it has nothing to do with syphilis.

No. III.—*Senile Diabetes with extensive Disease in the Choroid and Retina in both Eyes.*

Mrs. P——, an exceedingly stout Jewish lady, aged 70, but looking much younger, consulted me on March 24, 1886, on account of her loss of sight. She told me that she was the subject of diabetes, for which she had been under the care of Dr. A. Morrison, of Stoke Newington, for five or six years. She had also seen Dr. Pavy and Sir William Jenner. She was not aware that there was any gout in the family, but there was much “rheumatic gout.” I have attended several of her relatives, and should think it exceedingly probable that there is true gout. A sister, like herself, is very stout. Mrs. P—— said that she was losing strength, although getting stouter, and she

was very nervous. She complained of much general tenderness, saying that her skin was sore all over, and that a touch would bring out a bruise. She complained also of a bad appetite, but her sister said that she ate largely. Her tongue was exceedingly furred in all parts, thus confirming the belief that a valuable diabetic symptom is "a dirty tongue with a good appetite." On testing her vision, I found that she could only see letters of No. XX at one foot. She thought that she had not seen to read for nearly two years. The ophthalmoscope showed almost exactly similar conditions in the two eyes. There were delicate peripheral striæ in the lens, and large map-like areas of white near the region of the yellow spot. In some instances the vessels of the retina were seen crossing these patches, and not in the least obscured by them; and at the margins of some there was a delicate network of choroidal tissue remaining. I believe that the deposit was in the choroid, and not in the retina. It was not arranged in streaks or lines as in the retinitis of albuminuria. In some places there were groups of white dots almost like insects' eggs. Here and there in the retina were a few very small hæmorrhages; they were all round, not flame-shaped. I do not know any ophthalmoscopic plate which represents these conditions well. The disc was not affected.

Many cases of retinitis in diabetes have been recorded, and a discussion on the subject in which Mr. Nettleship, Dr. Mackenzie, and others took part, occurred at the Ophthalmological Society in 1881. Mr. Nettleship has published a portrait. I have myself seen several cases. The one which I now record seems of special interest on account of a certain amount of evidence that the deposit was in the choroid rather than the retina. I obtained a portrait of the fundus, which I shall be glad to show to any one interested. The patient is, I believe, still living.

No. IV.—*Choroiditis with extensive atrophy and changes like those of Retinitis Pigmentosa. No special cause assignable.*

Mr. H——'s case is one of much interest as an example of diffuse choroiditis ending in extensive atrophy and changes

like that of retinitis pigmentosa. There was no family history either of myopia or of tendency to blindness. Nor was there the slightest reason to suspect syphilis either inherited or acquired. Nor was he the offspring of a consanguineous marriage. Mr. H—— was a farmer, from near Salisbury, and was sent to me by my friend, Dr. Bevan Raike. He was of a dark complexion, and apparently in excellent health. He believed that the failure of his sight had been gradually in progress from boyhood, and he had noticed that he did not see well in the evening, but this latter symptom had not been well marked. He had a considerable degree of myopia, and he thought that he might possibly in former years have tried his eyes a little in reading music. Otherwise there had been no over-use. He said he was constantly employed in out-of-door employments. The sight in his left eye was considerably defective, and he could only just spell out No. 12. With his right eye he read No. 1, and with his own myopic glasses $\frac{2}{3}$. With — 7 D. he reached $\frac{2}{3}$. On using the ophthalmoscope I found the choroids very extensively atrophied, and large irregular patches which were chiefly located near the fundus of the eye. The difference between the two eyes was explained by the fact that the yellow spot was involved in the left, and had escaped in the right. The optic discs were in a slight degree waxy-looking, and there was also some slight appearance of opacity in the posterior pole of each lens. In addition to the extensive evidences of choroiditis, there were in the periphery of each eye the characteristic appearances of retinitis pigmentosa. These consisted in the formation of delicate lines and stars of pigment which were placed in front of the retinal vessels. Sometimes they ran parallel with the vessels, and at others crossed them. The pigment accumulations in connection with the choroidal atrophy were not large. In this case I could assign no cause for the choroiditis. It appeared to be aggressive, but with extreme slowness. It was very like what we often see from inherited syphilis, but I could not make out any suspicious facts in this direction.

DISEASES OF THE EAR.

No. I.—*On Gouty Seborrhœa of the Ear.*

A FORM of inflammation of the external ear which is in association with gout is characterized by repeated recurrences after long intervals of perfect recovery. Its recurrences are usually in association with other indications of gout existing at the time. It is in its nature what is called a seborrhœa-eczema, that is, it begins with increase of secretion from the ceruminous glands, which may easily be aggravated into general eczematous swelling of the whole ear. In many cases, perhaps in most, however, there is no evidence of eczematous complication. An itching, pricking sensation deep in the meatus is the first symptom of an attack. It not unfrequently begins rather suddenly, and it may begin in the night. The itching may be almost intolerable, and usually on introducing the tip of the little finger a sticky secretion is discovered. This secretion is much thicker and more waxy than that of a pure eczema, and it often also remains for long strictly limited to the deeper parts of the meatus. If the impulse to rub the meatus with the finger be yielded to, it is immediately followed by increase of heat and swelling, and there may be some approach to a general ear-ache, otherwise there is no material pain. The degree of deafness is for the most part proportionate to the completeness of the occlusion of the meatus. It is very little at first, but may be considerable before the attack ends. When the attack passes off the hearing is restored almost perfectly. During the attack there is an almost constant feeling of stuffing and fulness in the ear, and the patient feels inclined to pull the meatus open. There is often more or less of a low singing or humming. In many persons this singing, with the dulness of hearing, is

increased after food, but more especially and in a very remarkable manner by drinking strong coffee. During the time that the attack is on, the whole ear is remarkably susceptible, and the patient may be quite unable to bear the slightest breath of cold air on it, without an immediate increase of the symptoms, and a threatening of aching. Between the attacks, although the ear may be susceptible to wind, it may be perfectly able to bear all ordinary exposure. If the condition have been aggravated by rubbing or otherwise, the whole external ear may become red and thickened, and will tingle and burn, the condition being as much like recurring erysipelas as true eczema. It is to be especially noted that the condition hardly ever affects both ears simultaneously, and that it usually recurs in the one first affected. In this it corresponds with what happens with the recurring iritis which we observe in association with rheumatic gout. After one ear has suffered for a week or two the other may be affected, but seldom, I think, so severely as the first. The duration of the attacks is variable, but they usually last several weeks, and tend to pass away spontaneously. The intervals between them may be very short, or from six months to a year. Although more common in winter and cold weather, they may occur also in summer.

It may be asked whether the attacks described are not as much catarrhal as gouty, or whether they should not be described as catarrho-rheumatic rather than gouty. In reply to this I would say that no doubt they are mixed as regards their causation. That they occur chiefly in those who are distinctly suffering from gout, and who show at the time other indications of it, I cannot doubt. Most of the cases that I have seen have been in patients past middle age; I do not know whether the affection occurs in childhood or early adult life, but I have never at such ages seen a good example of it.

As regards the risk of permanent damage to hearing, it is clear that if the disease be of gouty origin it may easily be attended by implication of the auditory bones and middle ear generally. In many cases, however, it appears to recur over and over again without any material complication of the kind referred to. It may lead to thickening or even to

perforation of the membrana tympani, and if of frequent recurrence or long persistence it will certainly thicken the external ear and render it rigid. In some cases it is met with in association with a seborrhœa-eczema of other parts, more especially on the axillæ and genitals.

It is to be distinctly understood that although this affection has alliance with eczema and may pass into it, yet that it is very different from what we ordinarily mean by eczema of the external ear. It begins definitely, deep in the meatus, by an increase in the secretion of the ceruminous glands, and the implication of the external ear is always secondary. Its clinical course is also towards cure, and that often independently of treatment, whereas common eczema is usually persistent unless carefully cured by treatment. Common eczema may affect the external ear for years together, yet never pass deeply into the meatus, and never produce anything of the nature of seborrhœa. It is to be fully admitted that seborrhœa and eczema constantly complicate each other, or rather that the former is very often introductory to a dermatitis which receives the latter name. This occurs especially in parts where sebaceous glands are abundant and active, as, for instance, on the face, in the armpits, on the scrotum and adjacent parts of the thigh in the male, and on the labia, &c., in the female. Whether a seborrhœa shall or shall not be aggravated into an eczema depends very much on the patient's self-control and on the measures of treatment adopted. If the patient scratches or rubs, eczema will certainly follow, and so also if irritating remedies are used. These facts are well known to dermatologists. To the regions already recognized as specially prone to seborrhœa I now add the external auditory canal, with the assertion that a blood tendency to gout is a common cause of the affection.

An excellent illustration of recurrent gouty seborrhœa of the ears occurred in the person of Mrs. L—. This lady, the wife of a distinguished author, inherited gout from her grandmother and mother, and believed that it had occurred in many members of her mother's family. She was 62 years of age when she consulted me, and although she had borne a numerous family, looked much younger than her

years. It appeared probable that she had suffered from birth from a slight form of xeroderma. She had been troubled with eczema behind her knees and on the genitals, and on these parts the affection would come and go, causing much soreness when actively present. On one finger there was a distinct bony outgrowth (*nodus digiti*). She had never herself suffered very conclusively from articular affections either rheumatic or gouty, but her dietetic experiences were definite. All kinds of wines, she said, disagreed with her excepting champagne, and their disagreement was expressed by thick urine, and often by an attack of eczema. Beer, which she liked and which in early life she had been able to digest, now always caused thick urine and brought out her eczema. Dry champagne she could take with impunity. She was liable to a peculiarly bitter taste in the mouth, and of late had suffered much from lowness of spirits. Such were the general conditions of health under which Mrs. L—— had become liable to recurring attacks of deafness. These attacks were always introduced by great itching at the bottom of the ear, which was followed by a sticky discharge, swelling of the meatus, sense of stuffing and fulness. She said that she had never known the attacks begin in both ears together, but on several occasions both had been affected, and she had been for a time very deaf. She had had several attacks, and between them was accustomed to get almost perfectly well. I had attended several of Mrs. L——'s relatives and children for eczema. She thought that the eczema (or seborrhœa) of the genitals seldom occurred simultaneously with the affection of the ears.

In the case of Mrs. D——, I had another good example of the pruriginous seborrhœa of the ears in connection with history of gout. I had previously treated a sister of hers for troublesome eczema in connection with gout. I had also treated her grandfather for gout, and she herself was liable to flying pains in her joints, and had both her knees somewhat stiffened. Mrs. D—— was aged 59 when she consulted me, and had the appearance of good health. The description of her attacks was quite characteristic. She had had several of them, the first, three or four years ago. They always began with itching deep in the external ear, which was soon

followed by a sticky clear discharge. If she yielded to the desire to rub, the itching was converted into an intense burning which would involve the whole concha. The whole of the external ear would become red and slightly swollen, and the attacks usually ended by dry eczematous peeling. The attack from which she was suffering when she came to me was of nearly three months' duration, with variations. The attacks were always attended by much humming in the ears, sense of stuffing, and temporary deafness. This lady mentioned a symptom which I had noted in two or three other cases, namely, that frequently with the inflammation of the ears her nostrils would also become sore. The soreness chiefly affected the external orifice, and was attended by a tendency to crack.

No. II.—*A Case illustrating a form of Deafness which occurs after Typhoid Fever.*

The case of Mrs. B—— may perhaps be of interest and value as illustrating one of the forms of deafness which follow typhoid fever. She was under my care for other ailments, and I found her so deaf that it was necessary to shout loudly in conversation. On asking as to the cause of her deafness, she told me that it had followed typhoid fever. I became interested in obtaining the precise facts. The fever occurred, she said, twenty years ago, and was a most severe attack. She was not in the least expected to recover, and had been, she was told, for one month unconscious. She was six months in her bedroom, and had a large bed-sore. After her convalescence an abscess formed over her hip, which continued to discharge for a year or so. It had not left any stiffness of the joint. Mrs. B—— was married at the time of her illness. After her protracted convalescence she regained pretty good health, and had since borne several children. Before the fever her hearing was perfect, but when she recovered from it she was found to be very deaf and she has remained so ever since, with some variations and with perhaps on the whole slight improvement. No other special sense suffered, nor was there any form of paralysis. She had had no ear-ache nor

any discharge from the ears. As regards the character of the deafness, it may be stated to be unattended by any other subjective symptoms. She simply does not hear. By paying great attention she can hear a watch at a foot distance, but her apparent difficulty in conversation was far greater than this fact would seem to imply. It was doubtful if she could hear the watch pressed on her forehead. She had already been carefully examined by an excellent specialist (Dr. Hensman), and had been told that there was nothing amiss with the external ear, that it was nerve deafness, and that treatment would be of no avail. She had never been giddy and never had singing in her ears, nor ever experienced any sensation of stuffing. She could hear best when all was quiet, and could not hear at all if several people were speaking at once. Her deafness, she said, varied with her state of health. It always got definitely better when she was staying at the seaside and was worse whenever she fell out of tone.

It will be seen that we have here a form of defective hearing which has been, with variations, permanent but not in the slightest degree aggressive, and which is remarkable on account of the entire absence of all concomitant symptoms. It might perhaps be of some interest if those who have opportunities would examine as to the subsequent state of health, especially as regards the nervous system of those who have passed through long periods of unconsciousness in fever. This lady, although she had enjoyed pretty good health, considered that she had never been really strong since her illness. Amongst the symptoms for which she came under my care was the liability to very severe headaches, the pain beginning at the back of her neck and spreading to her head and causing her to "retch just like sea-sickness." Her arms were liable to become numb, sometimes on one side and sometimes on the other, and occasionally on both. After the attacks of numbness her limbs would ache. The numbness of her hands was often most marked just after breakfast, when quite independently of cold she often found herself unable to write. Her headaches, from which she had suffered for several years, would occur once in a fortnight, sometimes once in a week. The ailment which had brought her to me

was a non-malignant tumour in the breast. She was 52 years of age. It seems worth a thought whether during the long period of unconsciousness which she described, any permanent damage was done to the brain, of which the peculiar attacks of numbness were the result. If, however, the latter were in any such connection we must remember that, unlike the deafness, they had come on after a long interval since the fever.

SYPHILIS.

No. I.—*Deformation of the Skull in Congenital Syphilis.*

WHEN the peculiar forms of the skull in congenital syphilis were first recognized, I was inclined to attribute them to a transitory tendency to hydrocephalus. But the subsequent dissections of M. Parrot, and his demonstrations of periositis obliged me largely to abandon this explanation. It is possible, however, that in accepting periositis as the cause of all the peculiarities of the skull met with in these cases, we go too far. I am inclined to fall back on the first hypothesis, and to again believe that there is during the early stage of infantile syphilis some tendency to hydrocephalic effusion. Thus, as an instance, I have recently seen a little girl of six, who has a large projecting forehead, and wide head, and in whom the anterior fontanelle is not yet closed. The form of the head is more like that of hydrocephalus than that typical of congenital syphilis. In saying this I mean that there are no definite bosses. It seems probable that the hydrocephalic fluid has been wholly absorbed, for the unclosed fontanelle at the present time is deeply depressed. There is a history that in infancy the child had severe convulsions, and became for a time apparently blind; and there is now, in addition to extensive evidence of choroiditis, also proof of former neuritis, with extensive diminution of the central vessels. The child is believed to suffer from headache, but has no other definite symptoms, and looks well.

No. II.—*Facts as to the treatment of Syphilitic Disease of the Testicle. Recovery in most unpromising cases without Excision.*

The case of Mr. K—— is of considerable importance in reference to the saving of a testicle under very unpromising

conditions. When he came to me he had already had the right testicle removed, and the left was much diminished in size, and was exposed on all sides in an unhealthy ulcer close to the root of the penis. He had been advised to have this also removed, as it much disabled him, and the results of treatment had been disappointing. The removal of the right testis had been performed after a year's disease, two years ago. Doubts had been expressed at the time as to whether the disease was tubercular or syphilitic; it was taken away because it would not heal, and because it prevented his taking exercise. Mr. K—— was a strong, healthy looking man aged 32; but there was phthisis in his family, and his chest had at one time been suspected. Twelve years before I saw him, he being then twenty years of age, he went through a severe attack of syphilis. He was treated for three months by an eminent surgeon, by means of the mercurial vapour baths. At one stage, on account of high temperatures, the late Dr. Wilson Fox had been consulted. I could not feel sure whether the disease of his testicles was tubercular or syphilitic. On each side abscesses in the gland itself had been the most prominent symptom, and from the way in which the remaining testis had been drawn up towards the groin, it seemed probable that there had been suppuration along the vas deferens. My first impulse was to tell him that he had better fall in with the advice already given him, and have the damaged and apparently useless organ removed.

Supposing the disease to be tubercular there was, of course, much risk of infection. It is to be noted that he had no other indications of syphilis, and had had none with one exception since Mr. Lee's cure of him twelve years ago. The exception referred to was an abscess in one popliteal space, which occurred about the time that his right testis was first affected. The large scar which this abscess had left was so like that of a suppurated gumma that I at once determined to try the effect of syphilitic treatment. It is to be remembered that this had not been omitted before he came to me, but had been thought to be unsuccessful. I prescribed for him full doses of the three iodides, and sent him to stay at the sea-side. He returned to me in two months, with the

parts almost healed, and saying that he had gained two stone in weight. Six weeks later I saw him again, and gave him permission to return to India. The parts were quite soundly healed, and he was in excellent health. The testis which was saved was not bigger than half a walnut, and was held up by a puckered scar close beneath the root of the penis. He was in high spirits at his recovery, and was anxious for permission to marry.

From the result of treatment in this case there could be but little doubt that the disease had been from first to last syphilitic, and it is of interest to note the long period of good health which had intervened between the original disease and the tertiary symptoms. The case recalls to my mind one in which some years ago I assented to the removal of a testicle which was apparently disorganized by abscesses. The patient was a healthy man, of about fifty years of age, with a very doubtful history of syphilis in early life, and with a perfectly healthy family. He had had not the slightest reminder of his syphilis since; in fact, he had never had any secondary symptoms whatever. I thought that his suppurative orchitis had been produced by the use of catheters for stricture. After its removal it was found to be disorganized by abscesses, and surrounded by a large amount of fibroid thickening. No sooner was he well after the removal of this testis than its fellow inflamed, and an abscess formed in it. At length, becoming discouraged from the want of success of my treatment, he consulted another surgeon. This gentleman told him that he felt confident that it was syphilitic and seemingly proved his diagnosis by getting him well under specific treatment.

No. III.—*Hereditary Syphilis without definite peculiarities in teeth or physiognomy.*

A lady, aged 36, who had a son of 20, was under my care for tertiary syphilitic ulceration of her nose. She one morning brought her youngest child with her. The latter was a pale, fragile-looking girl of 13, of pretty features, bright eyes, and exhibiting nothing whatever in her physiog-

mony to suggest a taint of syphilis. Nor did her teeth show anything characteristic, though the upper central incisors were decidedly smaller than they ought to have been. On examining her forehead and skull I could still find nothing of bygone periostitis. She was brought to me for "rheumatism" of one knee; but on uncovering her legs I found both tibiæ considerably thickened by chronic nodes. There was a scar on one where an abscess had been opened. She said that her elbows were affected also, and I found both ulnæ affected with nodes in their upper and middle thirds. Her complaint was that she "could not sleep for aching of the legs." I could find nothing material amiss either with the knee joints or elbows, and although in each instance she considered the pain was in the joint, it was clear, I think, that it began in the bones. It did not appear that she had had much, if any, treatment for syphilis: she was taking hypophosphites and remedies for supposed rheumatism. On inquiring as to infantile symptoms, her mother used the expression, "She suffered from piles very much when a baby," meaning, no doubt, condylomata, but she did not recollect any other symptoms. (It curiously happens that I have often seen condylomata present in congenital syphilis in cases in which the child almost wholly escaped as regards other symptoms.)

Another symptom of minor importance, but still well worth thought, was present in this case. The child's legs were covered with brown stains (fire-stain melasma), and on inquiry I was told that she was an "extremely chilly subject," and was always cowering over the fire, "would get into it if she could." It may possibly be the fact that the chronic periostitis was the means of inducing a more or less constant arterial spasm, and thus of keeping her chilly.

No. IV.—*Very Severe Convulsions in a Syphilitic (?) Infant. Delayed Dentition. Absence of other symptoms.*

I had an opportunity of examining a little boy, who in infancy had suffered most severely from convulsions. His mother stated that he had had, in the first instance, a series of

forty-five fits, and in the second twenty-two ; and had several times been thought to be dead. The liability ceased at the age of nine months, and it did not appear to have been connected with the eruption of his teeth, for he did not get his first tooth till he was thirteen months old, and after that the whole of them came through easily. There appeared reason to believe that he was the subject of inherited syphilis, for his mother had suffered from palmar psoriasis and a sore throat during her pregnancy, and Dr. Trent, of Tooting, under whose care she was, had treated her for syphilis. The child, it must be noted, had never had any definite symptoms of specific disease.

With the above antecedents, I was interested in noting the condition of the boy at the age of nineteen months, when he was brought to me. He had then the appearance of excellent health, and showed no peculiarity of physiognomy. His teeth were well-formed, white, and in good condition. His anterior fontanelle was just closed. He appeared to be intelligent and easily amused. I should not in the least have suspected him as being the subject of inherited syphilis. Another child was, however, brought with him, aged two months, who was unquestionably suffering from specific symptoms. With the facts that his mother during the time that she was pregnant with him suffered from constitutional syphilis, and that a child born after him presented well-characterized disease, it is not possible to believe that he escaped. It becomes, therefore, very probable that his convulsions were due to the taint which he inherited.

No. V.—*Choroido-retinitis and other changes in a Child the subject of Inherited Syphilis.*

I wish to describe the precise conditions seen in the eyes of a little girl of six, whose antecedents were well known. Her father was a surgeon who had suffered from a chancre on his finger, and by accident communicated the disease to his wife during her pregnancy. The child, which thus acquired the disease *in utero*, suffered severely in infancy, and amongst other symptoms had repeated attacks of convulsions. After

one of these attacks of convulsions she appeared for a time to be blind. At present her state of sight is just sufficient to permit of her having learnt her letters in very large type · it is not possible to test her accurately. On examining her eyes after atropine, I found the conditions peculiar and not symmetrical. In both there were very extensive, but minute and inconspicuous changes in the choroid. There were numerous minute white spots and patches scattered over all parts of the fundus. Very few of these exhibited any pigmentation. Near to the periphery in both, but especially in the left, there were minute specks of pigment in the retina, like those in retinitis pigmentosa. In the left eye a very dense floating body, thick enough to look quite black, floated in the vitreous, being evidently attached. With this exception the vitreous was quite clear. In both eyes the retinal vessels were very small, but in the left they were extremely so. In the left eye the optic disc was surrounded by a rim of very black pigment, and it was itself very decidedly pale, but by no means white. In the right eye there was no pigment around the disc, but its margins were ill-defined.

No. VI.—*Chancre of Lip in a married Man. Pregnancy of his Wife. An infected Fœtus and contamination of the Mother.*

One Sunday evening in February, some years ago, a medical friend brought to me a patient, whose case was, he said, a peculiarly distressing one. The patient was a gentleman of about 30, who had been one week married, and was in London on his honeymoon. He had on that morning consulted Dr. R—— respecting a sore on his lip, which Dr. R—— believed to be a chancre. I was obliged to confirm the diagnosis, for there was not the slightest doubt about it. As usual, in my experience, in cases of lip-chancres, there was no evidence whatever as to how the sore had been contracted. We prescribed the usual measures and gave the proper cautions as regards the risk of infecting his wife. I saw no more of the patient, until the first week of November of the same year when I was asked to see his wife and an infant which

had been born to them. The precautions on which we had insisted had been neglected, and the result had been that his wife had been confined of an eight months' child just seven weeks before coming to me. Thus conception must have taken place within a month or two of marriage, and during the early secondary period in the husband. As the husband had never had any sore on the genitals and his wife had never contracted any primary chancre, either on lips, genitals, or elsewhere, we may consider that the case supports the belief, firstly, that a father may infect his offspring, and, secondly, that the foetus may infect its mother.

Mrs. S—— did not herself consider that she had been ill, but she had been made to take mercury, as a matter of precaution, almost from the middle of her pregnancy. She further admitted that she had several times had some blotchy spots on her body and arms. When she came to me seven months after her confinement she had a considerable number of dusky erythematous blotches on the fronts of the forearms, and superficial symmetrical ulcers on the tonsils. Both the sore throat and the eruptions were of recent development; she had had no sore throat until the last few days. There could be not the slightest doubt as to the nature of her symptoms. Her infant, seven weeks old, had been considered to be, for an eight-months' child, in a very thriving condition until the last few days. It was now, however, beginning to snuffle, had excoriations at its anus, and dusky erythema of its scrotum. There could be no doubt about these symptoms.

It is of interest to note in connection with the above facts that the mother did not suffer any outbreak of secondary symptoms until after her delivery. I have often observed this in other cases. It may have been that the mercury which had been given during the pregnancy, and omitted at the time of the confinement, had sufficed to keep the disease in check, but had not cured it. I believe that even during the pregnancy it had not been taken with much regularity, and some threatenings of an eruption had been several times observed.

DISEASES OF THE SKIN.

No I.—*Case of Ringworm of the Beard, showing the necessity for great care in the Diagnosis by the Microscope.*

A SHOPKEEPER from B—— came to me one morning, with the statement that he had got a ringworm on his chin which he had caught, as he believed, at his barber's. He had been to a barber whom he was not accustomed to frequent, and who he thought was not sufficiently cleanly. On going to his own barber some three days later, it was remarked to him, "why you must have had your chin scalded;" there being two red patches on it. From these there developed very quickly two large definite rings. It was six weeks between the supposed date of his infection, and his visit to me. In the meantime patches had occurred all over his chin and front of neck, and they had lost the character of rings, and consisted merely of raised areas which were red, and from which the epidermis was peeling. He had been using various remedies, and had perhaps modified it a good deal by them. Some of the patches did show in an indistinct manner the tendency to become crescentic. On inquiry as to whether he had any special reason to suppose he had been exposed to the infection of ringworm, he said, "No." He kept a boot-shop and had nothing to do with cattle or horses. He was not aware that there was any ringworm in his family, but said that one of his children, an infant, was suffering badly from eczema. He had been sent to me by a friend of his, a butcher, whom I had cured four years ago, of very bad ringworm of the chin, supposed to have been caught at the same shop.

What I have next to narrate concerns the difficulty and uncertainty which attends the microscopic examination. I pulled a number of hairs out of the patches and scraped off epidermic scales, of which there were plenty. Having treated these with glycerine, they were placed under the microscope, and after ten minutes careful inspection I could not find a single trace of fungus. I told my patient that I thought his case was one of eczema and not ringworm, but he persisted. "The rings were at first as if you had drawn them with a pencil, simply a ring and nothing in the middle. It must have been ringworm." So I asked which was the part first affected, and carefully pulled out some hairs from it. On examining these (about half-a-dozen hairs all looking perfectly normal to the naked eye), I found in two abundant evidence of fungus. One of these was crammed full with spores, so that I could distinguish nothing else in that part which was affected. Its end was somewhat brush-like, and a few loose spores adhered to its broken fibres. The other hair presented very different conditions. It was fairly transparent and showed no spores whatever, but branching mycelium in filaments of very great length and in tolerable abundance. In neither case was the root of the hair involved, and in both the cortex with the smallest possible exceptions appeared to be sound. In the evening I made a more prolonged examination of the hairs which I had extracted from three different parts of the skin, after long soaking, some in liquor potassæ, some in glycerine. With the exception of the two hairs mentioned, I did not succeed in finding either in epidermis or hairs any trace of fungus. Such a case well illustrates how easily the correct diagnosis may be missed in such cases, and how careful we must be in accepting a negative conclusion, based on failure to discover the fungus by aid of the microscope. The case also shows how rapidly ringworm may spread on the adult skin, the man had not only his chin and neck covered, but patches were appearing on his forearms. The fungus in all respects resembled that of common ringworm, and had the case been allowed to develop, no doubt we should soon have had inflammation of the hair follicles, and a typical example of "parasitic sycosis."

No. II.—*On the Infective Character of Boils as a Cause of their Multiplicity.*

I believe that in many instances boils are infective to their possessor, and that what is called “a crop of boils” are really the progeny, in successive generations, of the first. This doctrine is very important as regards treatment, since it strongly emphasizes the importance of curing the first as quickly as possible, and of following up a similar abortive treatment for each one in succession. I have elsewhere explained the *rationale* of this plan of treatment in reference to common pustular acne.

A gentleman, Mr. S——, aged 56, gave me the history that he had suffered severely from boils for a whole year. He had had, he said, more than a hundred, some large and some small. At one time he had at once so many that he kept his bed for a week. All sorts of treatment had been tried—arsenic, tonics, sulphide of calcium, &c.—and nothing had done any specific good. This severe eruption, so long continued, had been confined to the trunk, not a single boil had appeared on his limbs. It had begun on the left side of his chest, close to where he had just had a blister applied for a slight attack of pleurisy. All the earlier boils were near to the blister, and from that centre they spread over the abdomen, chest, and back. Mr. S—— was at the time living in a healthy house at a fashionable, but not bracing, seaside town. His surgeon examined his urine repeatedly, and never detected anything abnormal; nor was there anything in the previous state of his health to in any way explain the attack. The recovery was finally attained under such a combination of local and internal remedies, that it was not possible to say what had been most efficient. Now, this patient had never in his life had a boil before, and after once the cure was complete he remained quite free from them. There had been much discussion as to whether the outbreak was the expression of gouty tendencies, or of any other diathetic proclivity. Is it not more reasonable to regard it simply as a sort of accident, which had little or nothing to do with any special state of the general health? The blister set up local inflammation, and of this a boil was

the result. The first boil infected the tissues near it, and produced others, and thus throughout the whole chain of events the successive phenomena stood in the relation of cause to those which next followed them.

No. III.—*Large ulcers on the leg of a girl, looking like Syphilis. History absent. Cure.*

I feel sure that it is desirable to draw attention to the great difficulties which often attend the diagnosis of syphilis. We are sometimes inclined to make this diagnosis with too great confidence, and to insist too strongly on the value of peculiar appearances. There is no disease which syphilis cannot simulate, and there is no condition, however suspicious in its appearances, which can justify an absolutely confident diagnosis when the history is absent. I relate the following case in illustration of my statement.

A case sent to me by my friend, Dr. C. D——, presented most unusual difficulties in reference to diagnosis of inherited taint. She was from the country, and a rosy-faced, well-grown child of nine. She had good teeth, and showed nothing peculiar in physiognomy or shape of skull. Both her parents came with her, and both appeared to be in excellent health. She was the eldest of four, and none had died. Her father gave me the clearest possible denial of all history. It is scarcely possible to imagine a case in which the negative evidence could be stronger; yet this child had a number of large ulcers on one leg, which had they been met with under other circumstances would have been pronounced without hesitation to be specific. They were deep, with unhealthy, dirty secretion, and edges sometimes everted, sometimes undermined. They were spreading at parts, and healing in others, and were so extensive that they threatened to surround the leg. On the upper part of the back of the thigh on the same side there was a large thick scar, as big as a child's palm, which had been left after the healing of an ulcer, similar to those on the leg. This ulcer had been the first to form, and had begun about eighteen months before I saw the child, and about six months before those on the leg. It was described

as having commenced as a bad boil, and had been cured by the application of strong caustics. The other leg was quite healthy, and I could not anywhere find any proof of periostitis. I inquired as to the possibility of taint through vaccination, &c., but could get no help in that direction.

Dr. D—— had had the child long under treatment before I saw her; had tried change of air, liberal diet, and in addition to various local applications, the bi-chloride of mercury internally.

Although much temporary benefit had at times been obtained, nothing like a cure had resulted, and no remedy had appeared to exert any specific action. I was told that the child had once had an acute attack of inflammation of the eyes, but of this, neither in cornea, nor iris, did the slightest evidence remain. It was as difficult to call the ulcers strumous as syphilitic, for neither child nor parents showed anything in the least indicative of that state. No trial had as yet been made of systematic rest. The child had indeed been encouraged to be much in the fresh air. I advised that a two months' rest in bed should be resolutely carried out, and that the ulcers should be dressed with iodoform, and if that did not succeed, cauterized with the acid nitrate.

Six months later Mr. Dukes was kind enough to inform me that under absolute rest, &c., followed by elastic bandage, the leg had got quite well, and that it remained so.

I have more recently, in the person of a young lady who had been brought over from Normandy, seen an almost exactly similar case. There was no feature wanting which might suggest tertiary syphilis. Yet the evidence was in the strongest possible manner negative. The ulcers proved most difficult to treat. In both cases I believe that the conditions assumed depended upon feebleness of circulation and individual peculiarity, and not upon specific taint.

No. IV.—*On the Lichen Ruber of Hebra.*

Dr. R. W. Taylor, of New York, has just given us a very important clinical report on Lichen Ruber. It is accompanied,

as is usual with all that he writes, by the detailed citation of facts which have been very carefully investigated. Dr. Taylor gives us first an excellent coloured illustration of his patient's skin, next a full report of her case, and lastly numerous illustrations of microscopic sections of the parts involved. The clinical features of the disease are certainly brought out with a definiteness which I think no one had previously attained. According to his delineation we see in lichen ruber a disease of well-marked individuality, but not a true "lichen" at all, if we are to imply by that term any implication of hair follicles or glands. Its anatomical features consist in hypertrophy of all the layers of the epidermis, accompanied with some exudative inflammation in the papillary layer. The deeper structures and the glands escape entirely. It is an affection which begins without any obvious cause in persons of good health, and the course of which would suggest that it is a chronic, self-infecting form of inflammation. Those who have had it once are liable, after an interval of perfect recovery, to have it again. Its development is very slow, six months to a year or more, and after having reached its height it may disappear almost spontaneously. The appearances presented by the skin are a number of little, conical, waxy-looking, papules of light-brownish red colour, which soon become flat and shiny, and are almost without desquamation. The papules do not grow beyond a certain size, but fresh ones form near to them and by coalescence very large areas are covered. The ultimate condition is a slight thickening and induration of the skin, with exaggeration of its natural furrows, so that it looks and feels like thin leather. At all stages the disease is remarkable for the uniformity of its lesions, there being not the slightest tendency to polymorphism or deviation from type. It would appear to begin usually on the upper parts of the trunk, and to spread very slowly downwards over the body and limbs. It may affect the palms and soles, and may impair the nutrition of the nails, and of such hairs as are met with on the trunk. It is not known to affect the mucous membranes. It is not attended by much local irritation, but is usually accompanied, when extensively developed, by emaciation and loss of strength.

It usually spreads over the face, and on the scalp a condition of desquamation is produced. Dr. Taylor's patient was a healthy Swiss woman, aged 37, who had her first attack immediately on her arrival in New York. This lasted her a year and then disappeared under negative treatment without leaving a blemish. A year after her recovery she was again affected, but the eruption was not so extensive as on the first occasion, and passed away in a few months. Eighteen months later the third attack (that which Dr. Taylor describes) commenced. It began by groups of pimples on the neck, top of sternum, and about the chin. It was confined to the regions mentioned for at least two months, and during the next eight months spread gradually, though not in a continuous manner until it involved the whole of the trunk and limbs. This attack was in its tenth month at the time of Dr. Taylor's description of the case.

It is of interest to contrast this account with that given by Hebra, who was the first to describe lichen ruber. On the whole, it does not differ much from it. Hebra insisted upon the fact that the little papules themselves did not undergo any material change, nor any peripheral growth; that they did not itch and were attended by very slight evidences of inflammation. The extension of the disease was, he said, by the production of new papules and their coalescence into large, ill-defined areas. He noticed the affection of the palms and soles, and of the fingers and their nails, and also that the hair of the head, pubes, and axillæ, escaped; while that of the trunk in general might degenerate. He described the latter stage of the disease as being of greater severity than that encountered by Dr. Taylor; but this impression was modified, I believe, by his subsequent experience, when he found that all the cases ended favourably if arsenic were given. His account differs a little from Dr. Taylor's in his representing that the eruption occurs, in the first instance, on the limbs, and also in the statement that the chief morbid change discovered by the microscope was in the root sheaths of the hairs. Not having witnessed many cases of recovery, and regarding it, unless treated by arsenic, as a slowly but certainly fatal disease, Hebra says nothing as to its re-

currence after an interval. At the time that his first paper was written (more than twenty years ago) he had seen fourteen cases, of which several, perhaps most, had ended fatally. After accounting for three, he writes: "All the others perished before my eyes in spite of careful nursing and the administration of various remedies." His later experience was, however, that all treated by arsenic did well. Hebra could assign no cause whatever for the disease; but of his fourteen cases thirteen occurred in males. Some of the patients were youths between thirteen and twenty, but some were more than forty years old, and appeared to be in perfect health; no inheritance was traced in any. I do not find that he assigns any very definite duration to the malady.

At the time that Hebra wrote it was necessary to establish the diagnosis of the new disease only as regards others which were well known, and he constructed an elaborate table giving its differential diagnosis from lichen scrofulosorum, psoriasis, eczema, and pityriasis rubra. It is not now necessary, at any rate for specialists, to take these maladies into any consideration, for, in regard to lichen ruber, their differences are conspicuous and well known.

Another disease has, however, come into prominence since Hebra wrote, which presents greater difficulties. I refer to the disease which Wilson first described, and which we know in England as lichen planus. Much perplexity has occurred owing to a confusion of these two maladies. In England, lichen ruber, of the original Hebra type, and like the case which Taylor has now so well recorded, is probably very rare; and it may perhaps be the case that English authorities, who have written respecting it, have never really had an opportunity of examining a well-marked example. Lichen planus, on the other hand, is by no means so infrequent, and from it most of our descriptions have been written. Nor were our colleagues in Vienna wholly free from ambiguity on this point, for Kaposi described an acuminate as well as a plane lichen ruber. Dr. Taylor devotes the greater part of his paper, and I think successfully, to the endeavour to establish a diagnosis between the two. This diagnosis, let me say, had been quite as definitely laid down, some years before, by his

fellow citizen, Dr. A. R. Robinson. Dr. Taylor, however, places the points of diagnosis very conveniently in parallel tables. Lichen planus, which would appear in America to be more common than lichen ruber, he describes as an affection of the deeper layers of the skin, more decidedly inflammatory, producing hard, rough, dark-brown patches, which desquamate a good deal; produced symmetrically in discrete patches, and chiefly on the limbs, its papules increasing by peripheral growth and undergoing changes independently of one another, rarely affecting the palms and soles, never the face, and scarcely ever the nails. It may affect mucous membranes, as the mouth and glans penis, is often attended by severe itching, but does not produce any definite failure of health. It might seem that these features would have sufficed to supply a definite distinction between the two; but the maladies in question have one point in common, and in connection with this mistakes have come about. It is that in both the papules many take on a smooth and polished surface; this is universal and invariable in lichen ruber, and in lichen planus it is almost always found in some of the spots. In making our diagnosis of the latter we always seek, it may be on the wrists, or on the ankles, or on the abdomen, some spots which have become polished and shiny. Very often the majority of the patches are not polished at all, but rough and papillary, and it may be so scaly that it is difficult to distinguish them from psoriasis or dry eczema. No such difficulty is encountered in lichen ruber. Dr. Robinson (of New York) follows Hebra in his statement that lichen ruber is fatal, if not cured by arsenic, and he gives woodcuts representing microscopic sections of the skin. He gives, unfortunately, however, no definite statement as to his personal experience of the disease.

DISEASES AND INJURIES OF THE NERVOUS SYSTEM.

No. I.—*Delivery by Forceps. Rupture of the Roots of the Brachial Plexus in the Infant. Statement of the conditions two years later.*

DR. CHARLES KNIGHT, of Brixton, brought to me an infant of a year old, in whom it seemed probable that the brachial plexus had been torn through at the time of delivery. It was a forceps case, and it had been necessary to use much force. The clavicle was broken near its acromial end, and possibly the scapula also. The arm now affected had appeared to be paralysed from the first.

I saw the child when a year old, and again at the age of two years. In the interval galvanism had been employed.

At the latter date (Dec. 12, 1888) the arm was quite helpless, and the hand dusky-red and cold. The fingers were contracted into the palm. I was told that the child would occasionally move the thumb a little. I could not elicit any action in any of the muscles. The deltoid was wasted. Both shoulder and elbow were somewhat stiffened by muscular contraction, but there was no ankylosis. It was impossible to test sensation accurately in so young a child, but there could be no doubt that it was very defective in the whole limb. Galvanism had, in the first instance, been borne apparently without its producing any sensation, but latterly the child had cried when it was used.

I examined carefully for eye symptoms, but, excepting that the palpebral fissure was certainly narrower than on the other side, there were none. The pupil dilated in the shade. The ears were alike in temperature.

I have published elsewhere* several examples of laceration of the roots of the brachial plexus from violence, and cases have also been recorded by others. This, however, is the first instance, so far as I know, in which the accident has occurred to an infant during birth.

No. II.—*Symptoms of Arachnitis after a fall on the Head. Recovery under treatment by Mercury.*

I saw, with Dr. Taylor, in Gloucester Road, Kensington, a gentleman in whom somewhat peculiar head symptoms had developed after a fall. It was on the fourteenth day after the accident that I was consulted. The accident had happened in the Scilly Islands. Mr. Q—— had inadvertently walked down some steep stairs without observing them, and fallen a considerable height, cutting his face and forehead. He was a good deal stunned at the time, but not unconscious. He did not bleed from the ears, but blood came from his nose and mouth. He vomited soon afterwards, and was purged. On the next day he insisted that he was well enough to travel, and took the packet to Penzance, stayed the night, and returned to London. On reaching his home he was able to walk upstairs, but throughout he had been feeling far from well, and he at once took to his bed. It should be stated that there had been at first echymosis of the conjunctiva of the left eye, and this, taken in conjunction with the bleeding from the mouth and nose, may be held to indicate the probability of a fracture of the anterior part of the base of the skull. Dr. Taylor told me that during the ten days he had attended Mr. Q—— there had been perfect consciousness, and no very marked symptoms, excepting pain in the head and double vision. The latter condition was due to partial paralysis of the right adductor, and occurred only when he looked to the right. There had been not the slightest defect of any limb, nor any failure of the sphincters. Up to the time of my visit Mr. Q—— had been accustomed to get out of bed to relieve his bladder, and although assistance was given him in standing, he said he did

* See "Illustrations of Clinical Surgery," vol. i. p. 204.

not need it. The day of our consultation his friends had become alarmed by his having a tendency to wander, and his not wishing to speak. He had had during the night an acute attack of pain in the head. He did not refer the pain to any particular part. When I saw Mr. Q—— he preferred to keep his eyes shut, although there was very little light in the room. His memory was perfect, and he gave me a very clear account of his illness. He had a furred tongue, and his temperature was 102°. The temperature had varied from 100° to 102°. There had been no convulsions or rigors. I suspected a fracture in the anterior part of the base of the skull, and secondary inflammation of the sub-arachnoid spaces. It was decided to use hot pediluvia very frequently, and to push mercury to salivation.

I may state the treatment and its results very briefly. Mercury was given for about a fortnight in small but very frequent doses. The pain in the head ceased within a few days, and the temperature came down. In about a fortnight Mr. Q—— was able to leave his bed. He has since quite regained his health. The sixth nerve is still paralysed. Only slight ptyalism was ever produced, but it was kept up for some days. The pediluvia had probably some share in the cure. He had been made to sit for half an hour at a time, three or four times a day, with his feet in water as hot as could possibly be borne.

January, 1889. It is now three years since I attended the case described above. I have seen the patient once or twice in the interval, and again quite recently. He suffered for some time from diplopia from weakness of the right sixth, but it has now quite disappeared. He can read the smallest print with each eye, is free from headache, and enjoys on the whole excellent health.

No. III.—*Case of complete loss of Hearing from a fall on the Head.*

A man aged 22 came under my care at the Ophthalmic Hospital, on account of myopia. The chief interest of his case, however, was in connection with the fact that he was

absolutely deaf, and that his deafness had occurred suddenly after an injury to his head. No other function of his nervous system seemed to have suffered in the least. His deafness was so complete that I was obliged to question him in writing, and the information obtained as to his accident was necessarily somewhat meagre. I will give it exactly as I got it, in the form of question and answer.

Q. Could you ever see well ?

A. No, I was always short-sighted.

Q. Were you deaf before your fall ?

A. No. I could hear perfectly well.

Q. After the fall were you laid up long in bed ?

A. I was five weeks in the hospital.

Q. Were you stunned ?

A. Yes.

Q. How long do you think you were insensible ?

A. About a quarter of an hour.

Q. Did you bleed from the ears or nose ?

A. No.

Q. Were you deaf as soon as you came to yourself after the fall ?

A. Yes, just as I am now.

Q. Why were you kept in bed so long ?

A. I had very bad headaches.

Q. Were you paralyzed ?

A. No.

Q. Had you any running from the ears while you were in the hospital ?

A. No.

Q. What height did you fall ?

A. About nine feet.

Q. Did you strike the top of your head ?

A. I believe I pitched on the left side of the head.

Q. Can you smell well ?

A. Yes.

It was two or three years after the accident when this man came under my notice. He was intelligent and cheerful, and appeared to be in excellent health.

Loss of hearing on one side only is a very common symptom

after injuries to the head, and I have known several cases in which the patient has made a perfect recovery with the exception of remaining totally deaf in the ear and with facial paralysis on the same side. When these two symptoms go together there can be little hesitation in accepting the explanation that the petrous portion of the temporal bone has been fractured, and the two nerves which pass through it irreparably damaged. Nor is it very difficult to account for loss of hearing when it occurs without facial paralysis. In such instances it is common to find that blood has been effused into the chambers of the ear. If the fracture have occurred behind the membrana tympani, this may easily happen without there having been any bleeding from the meatus. I possess a drawing from a case of this kind; the membrana tympani was entire, and the tympanic cavity filled with blood-clot.

It is at first sight much more difficult to explain a case in which the deafness is on both sides, and with symmetrical escape also of the portio dura. At first sight in such a case most would, I think, feel inclined to suspect the nervous centres rather than the bones through which the nerves pass; it seems so improbable that on both sides the portio mollis should be damaged and its fellow nerve escape, or that on both sides a fracture should open into the tympanum, yet not rupture the membrana; yet that this singular coincidence does occasionally occur I can give clinical proof.

A patient whose skull I possess was rendered absolutely deaf by a fall on his head. He had no paralysis of his face. He regained perfect consciousness within twenty-four hours of his accident, and had it not been for an attack of erysipelas it is probable that he would have recovered. Had he recovered his case would have very exactly resembled that of the man whose condition I have just described, for it is probable that he would have been absolutely deaf without any other symptoms. I have published the details of his case in the Transactions of the Pathological Society. It will be sufficient for our present purpose if I give a brief *resumé* of them.

He was brought into the hospital one Tuesday morning, having received a severe laceration of his scalp from a fall

into a ship's hold. On the day following the injury he had regained full consciousness, and had no degree of paralysis; he would put out his tongue when signs were made, and when we spoke to him he replied with a shout, "I can't hear." His deafness continued until the time of his death (on the eighth day). I will omit some very interesting facts supplied by his case, in reference to the diagnosis of compression, and confine my attention to the symptoms having reference to his temporal bones. On the day of his death, my notes state that he could still use his facial muscles.

At the *post-mortem* we found lines of fracture passing out from the foramen magnum on each side, curving forwards and outwards through the petrous portion of each temporal bone, and meeting in the body of the sphenoid. On both sides the tympanum was full of blood, and on both the membrana was entire. Here, then, we have a full and satisfactory explanation of the symptoms under discussion. But perhaps some may be inclined to reply that the case is not applicable to the explanation of the one which I have just narrated, since, inasmuch, as the man had an extensive fracture of the base of his skull, it is very improbable that he would have recovered. I cannot, however, by any means admit that it is rare for fractures of the base to recover. It is but seldom that we are able to prove that such fractures have occurred in cases in which the patient has got well; but I feel no doubt that recoveries after injuries of this kind are not by any means uncommon. There is no reason why recovery should not occur, nor why, supposing air not to have been admitted, a fracture of the base of the skull should not be repaired, just as a fracture of any other bone. It may be reasonably asked, however, whether, supposing complete deafness to have been produced by distention of the chambers of the middle and internal ear with blood, it is probable that the deafness would persist? In answer to this question I have no facts to adduce. Either event would, I should think, be possible, permanent deafness, or more or less complete recovery; and, as a matter of fact, we do know that most of those who are deaf for a while after injuries to the head subsequently regain their hearing. In some of these the deafness

may have been due to stretching, contusion, or even laceration of the trunk of the nerve, but in others it is very probable that blood-clot in the ear chambers was the cause. Probably much will depend upon the extent to which the internal ear is damaged; in some cases, possibly, the blood has not gained access to the semicircular canals. It is certainly rare for a patient to regain anything like good sight, in a case in which the eyeball has been filled with blood after an injury, and there is nothing but what is very probable in the supposition that permanent loss of hearing might result from a parallel lesion.

In reference to the loss of hearing after injuries to the head, I may then mention several different causes as possible. 1st. The portio mollis may have been torn through within the cavity of the skull, as the result of sudden movement of the brain (in such a case it is probable that the portio dura would suffer also). 2nd. The petrous portion of the temporal bone may have been fractured with displacement and laceration of the nerve trunk (here again in all probability facial paralysis would accompany the deafness, and both would be complete). 3rd. With a fissure fracture of the petrous bone and no displacement, it is quite possible that the nerve trunks may have been contused but not torn through, or that blood may have been effused around them; in this condition the loss of function would be either partial or complete, and it would, very probably, not be permanent. 4th. Either with or without damage to the nerve trunk, fracture of the petrous portion may have caused effusion of blood into the middle or internal ear one or both. 5th. There may have been rupture of the membrana tympani. 6th. It is quite possible that a degree of deafness, probably merely temporary, may have been caused by the presence of blood in the external meatus.

I have left to the last the suggestion that it is possible that an extravasation of blood in some part of the nervous centres may extinguish the function of hearing, and that it may do so either on one or both sides. Histological research would certainly bear us out in the belief that there is a central part, the disintegration of which would effect this

result. If, however, we try to realize the manner in which extravasations occur in the central parts of the brain, we shall certainly be disposed to admit that it is extremely improbable that such a cause could totally abolish a special sense without doing anything more; it is like Shylock's pound of flesh, difficult if not impossible to take with exactitude. Such effusions may, perhaps, not infrequently account for the partial loss of a special sense, or for its entire abolition in association with more extensive forms of paralysis. When however, we find no symptoms whatever, excepting the loss of hearing, and that loss absolute, we are obliged, as far as our present facts go, to infer that the damage has been done outside the nervous centres, either in the sense-capsule itself, or in the nerve cord which connects it with the sensorium.

CURES; SCHEMATA OF TREATMENT; AND THERAPEUTICS IN GENERAL.

No. I.—*The local treatment of Psoriasis.*

My favourite prescription for psoriasis is the following—

R Acid., Chrysophanic, gr. x.

Liq., Carbonis Deterg. (Wright's) m x.

Hydr., Amm.-Chlorid, gr. x.

Adip., Benzoat., ℥j.

Miscè fiat Unguent.

The patient is instructed to remove all scales as much as possible, either by washing or a warm bath, and then to spend half-an-hour (before a fire if the room be cold) in rubbing this ointment into all patches. It is better to leave the ointment on all night, but if this is, for any reason, too disagreeable, it may be wiped off (not washed). In the morning a bath with soap is taken. In most cases I prescribe arsenic, along with the local treatment, as helping the cure, and tending to make it more permanent, but I rely chiefly on the ointment, and sometimes use it alone. I have published* a portrait, in which it was used on one side of the body only, whilst arsenic was given internally, the result being the disappearance of the eruption on the parts treated locally, whilst it still persisted on the others. This experiment was conclusive. It will be observed that the quantity of chrysophanic acid is but small, and I may say that I often prescribe a yet weaker ointment. Strong ointments both irritate and stain much more, and not unfrequently the patients naturally refuse to continue them. With this ointment there is but little risk of inconvenience, and patients rarely complain

* See "Illustrations of Clinical Surgery," vol. ii.

much of the staining, especially if they are allowed after a prolonged inunction to rub it off at once. This formula has been for many years in constant use at the Blackfriar's Hospital for Skin Diseases, and gives great satisfaction. I believe that the tar solution often has a material effect in preventing staining. As years go on I find that I prescribe arsenic with increasing caution, and rely more and more upon local treatment of the kind indicated.

As an illustration I will quote the experience of one of the last psoriasis patients whom I have seen. Mrs. A—— consulted me in June, 1888, for common psoriasis, from which she had suffered for twelve years, and for which she had had much specialist treatment. I ordered arsenic and the ointment above mentioned. I did not see Mrs. A—— again for ten months. She then came to report that the ointment was so effectual that she had long ago left off the mixture. Her experience was that two weeks of the ointment always removed the patches, and that after a six weeks' interval they would usually begin to threaten again. At the time of her visit her skin was absolutely free. The ointment she said always left her skin brown, and it took a week or more for the discolouration to wear off. Then followed a month of a perfectly clean skin, and then a few spots would again show themselves. Thus she could always keep the eruption in check, though it was never permanently cured. This, I fear, is almost as much as we can expect in most cases of psoriasis. With perseverance, however, the relapses become more and more slight, and the intervals longer, so that in the end the disease is virtually cured. The reverse is the fact if psoriasis is neglected.

No II.—*Simulation of Hodgkin's Disease in Syphilis (?) Immense glandular tumours removed under Iodides. Does a cure by specifics prove specific nature?*

I find in Dr. Mc'Call Anderson's interesting brochure, just published, on "Syphilitic Affections of the Nervous System," a very noteworthy example of the cure of an immense glandular

tumour by iodide of potassium. Not only is the case important as an instance of recovery from a very formidable complaint, but because it raises the question as to how far we are justified in regarding recovery under the iodide as proof of the syphilitic nature of any malady so cured. The case was one which was at first considered to be Hodgkin's disease, the patient, a man of thirty-five, apparently in "perfect health," having enlarged glands in both sides of his neck. The tumour on the right side is described as "enormous," and as having first commenced two years ago behind the ear. Not only were the cervical glands enlarged, but those also in the axillæ and inguinal regions. On the right side the tumour extended from the middle of the neck to several inches below the nipple, and measured fourteen inches in length, and ten in width. It was crossed by enlarged veins, and at parts the skin was reddened. The patient had been accustomed to laborious work, and had drunk freely; he was, notwithstanding, "well nourished."

In the belief that the disease might be syphilitic, iodide of potassium in large and increasing doses was ordered, and the man was advised to abstain from all labour. The salt was commenced in doses of ten grains, and increased to thirty-three times a day. It was begun on the 29th of January, and the improvement was almost immediate. On the 12th of July, Dr. Hugh Cunningham, of Dumfries, who was in charge of the patient, wrote, "You will be glad to hear that the tumours have almost entirely disappeared, scarcely a vestige of any of them now exists."

We have, then, in this case, a clear and definite instance of recovery from a general tendency to enlargement of the lymphatic glands, under the use of the iodide of potassium. Does the cure by this remedy prove that the disease was syphilitic? I cannot think that it does. I have never seen enlargement of lymphatic glands advancing to the condition described in this case in connection with syphilis; and further, the evidence of the man having had syphilis at all is very slight. The case is, in all its features, a typical one of lymphadenoma; in other words, of general infective enlargement of lymphatic glands without tubercle. We must re-

member that iodide of potassium and iodine gained repute in the first instance as remedies for enlargements of glands. It was only after their credit had been well established for this disease, and for bronchocele, that they came to be employed for syphilis. In making these remarks, I by no means wish to be considered as expressing an opinion that the disease in question was not syphilitic. I merely raise the doubt, and demur to the doctrine that the mode of cure proves the nature of the disease. Whatever the latter may have been, the fact of the cure is of great interest, for we are not accustomed to see any form of lymphadenoma yield so quickly and definitely to treatment. More usually this malady resists all our remedies.

No. III.—*Arsenic as a cause of Herpes Zoster and of Dull Eyes.*

I prescribed arsenic, in very full doses, for Mrs. H—, in order to cure psoriasis of the nails. It was effectual; and she took it regularly for several months. In March, 1888, she reported to me that about the previous Christmas she had suffered a most severe attack of shingles on the right side of her chest. Her surgeon, in Yorkshire, where she was, had told her that he had never seen a case with so much inflammation. Fortunately for me he had not suggested to her any suspicion as to its having been caused by the medicine. The latter was, however, discontinued, as Mrs. H— was suffering from a cold.

In this case, my patient was strongly of opinion that the arsenic did not improve her personal appearance. She was greatly distressed by the state of her nails, and willing to do anything for their cure, but she thought that the arsenic made the whites of her eyes look thick and a little yellow. The blue of the sclerotic, which in her showed through, did not do so as much as usual. A friend who lived with her had assured her that the medicine made her eyes look dull, and that the blue iris became more grey. I could myself somewhat confirm this impression, for Mrs. H— certainly looked older, and had a less brilliant complexion than for-

merly. She was naturally fair and florid. The nails, which had got well when the drug was pushed, had somewhat relapsed during the two months during which it had been left off. The arsenic had not disagreed in any other way.

By several observers cases have been published in proof that in some obscure manner the skin may be made muddy and dull by the medicinal use of arsenic. I have myself given an extreme illustration of this in the *Pathological Transactions* for 1888. In this instance the skin became earthy and brown, and in some places took on the condition of psoriasis. Pricking of the eyes and redness of the conjunctiva are also well-known results. The patient whose case I have given above is, however, the first who has complained of objective dulness of the eyes. She was an acute observer, and so was her companion, and I have no doubt they were right. It is quite certain that arsenic does affect the nutrition of all the tissues and produce changes, it may be very minute at first, concerning the precise nature of which it is difficult to give any explanation. In arsenical herpes zoster we have a definite form of peripheral neuritis, but it is far from being the only disturbance of nutrition which we witness in connection with the use of this powerful drug.

MISCELLANEOUS MEMORANDA, EXTRACTS AND REVIEWS, &c., &c.

No. I.—*On some curious Phenomena of Quiet Gout.
Pain in the Knee evoked only in the act of kneeling.*

THE expression "quiet gout" may, I think, be suitably employed as applicable to the many cases in which those who are gouty experience no material inconvenience. Such symptoms as do occur are perhaps rather a source of amusement and joke than of real pain or trouble. Very often they are quite misunderstood, but many persons of gouty proclivities know exactly what they mean and at once take their dietetic measures accordingly. The term "latent gout" is perhaps of almost equivalent meaning. The phenomena by which this condition is recognized are infinitely varied and some of them very peculiar. They are well worth detailed study, not alone on account of their value as "revealing symptoms"—that is as betraying what would otherwise remain unrecognized—but because they present us interesting problems as to the precise method of their development. A great many of them are probably caused by locally restricted forms of peripheral neuritis. I will describe such an one by way of illustrating what is meant. A gentleman passed middle age, who had never suffered from an acute attack of gout, but who for many years had experienced many warnings, became the subject of a very real but almost ludicrous affection of one knee. He could walk quite well, could bear to have the knee handled in any way, and there was not the slightest swelling. There was one thing, and one only which he could not do without pain—he could not kneel on any soft substance. If he took care how the knee was placed on a hard floor he could bear the pressure without any pain for some

time, but to kneel on a cushion might produce an explosion of pain which would make him cry out. He was often, so to say, "caught" when in the act of getting into bed he knelt on the soft bed. The pain was of the nature of a local explosion, and was quite limited to an area the size of a crown piece. Very curiously after one explosion had occurred it was difficult to produce a second which should in the least approach it in severity, and after two or three shocks he could kneel firmly without any pain whatever. The liability to these attacks, which occurred invariably every night unless he was careful not to put the knee on the bed, lasted for a month or two, and then under treatment by alkalies and a more restricted diet passed completely away. A year later however, the liability returned, and again lasted a month or two. It has been since threatened on several other occasions. Another symptom which confirmed the suggestion that something of the nature of peripheral neuritis was the cause of this liability was, that the skin in front of the knee became for a time very decidedly anæsthetic. The numbness disappeared gradually after the liability to pain went off.

It is not very often that our patients will describe their symptoms to us with the accuracy and detail given in the above statements; but it so happened that I was about the same time consulted by another patient equally intelligent and observant, and who had experienced precisely the same thing. There was the difference, however, that in him the pain was more persistent, and that he could not kneel under any conditions. Still, however, a soft substance was the means of finding out the pain much better than a hard one. On my mentioning to him what my first patient had described as to his difficulties of getting into bed, he exclaimed, "That is just my case; I have to wriggle into bed any way I can to avoid pressure on the knee, but when once in, I am quite free from pain." In both these cases the proof as to gout consisted in the fact that the patients were liable to twinges and prickings in the joints; and that their symptoms were in the most definite manner influenced by the kind of wine which they took.

No. II.—*Statistics of Disease Seventy-five Years Ago.*

One of the earliest of English contributions to the statistics of prevalence of different diseases was made by Sir Gilbert Blane. It is to be found in the Transactions of the Medico-Chirurgical Society for 1813, and contains information of great interest. Sir Gilbert states that he had kept records of his practice at St. Thomas's Hospital for ten years, and of all his private cases during the same period.

Amongst other matters I note the following:—

Gout was common in private, but unknown in the Hospital. "Not a single case of it is to be found in the Hospital list, whereas there are in the private list a hundred and thirty, constituting about a twenty-sixth part of the whole. No disease affords so strong a proof of the power of habits of life over health." Whether it may be taken as proof that the habits of the labouring classes have changed during the last half century or not, I do not know, but there can be little doubt that St. Thomas's would now show a certain number of cases every year. Even our workhouse infirmaries are never without their cases of true gout. The tables of St. Bartholomew's for 1887, show no fewer than eighteen cases with one death. Amongst Sir Gilbert's Hospital cases there were 751 of rheumatism, with a mortality of only 13. It is expressly stated that very few of them were acute cases.

Venereal complaints give a total of 202, with a mortality of 3. No details are afforded.

Amongst the rarities are to be noted a death from wound of the epigastric artery in tapping, and a case in which it is asserted that "the menses came from the navel."

The nomenclature of the hospital cases is far less detailed than that used for Sir Gilbert's private patients. He would appear to have been no pedant, and English appellations are for the most part employed. We have a case of "Intolerance of touch on the whole skin," and two of "Excessive sensibility to cold." Both these terms are, I believe, well descriptive of the prominent feature in conditions of health which have not even yet received any better names nor even any special clinical notice. The latter is perhaps a form of Raynaud's

disease. "Swine-pox" is used as a term equivalent to "pemphigus." One case is recorded as "Flatus per vaginam," clearly the name of the symptom only, and three are put down in plain terms as "excess of venery," a designation of the cause but not of the malady. Rickets, not mentioned in the Hospital list, has only four cases out of near upon 4,000 *private* patients. Out of this large number only 32 are mentioned as venereal, probably a far smaller proportion than any physician of the present day is accustomed to diagnose as such. Skin diseases are with very few exceptions lumped together under the head of impitiginous affections (160). Carbuncle has only three cases, and only one death. Shingles claims five cases, and the following item of interesting detail is given: "The patient after recovery was for the remainder of her life, which extended only to a few years, almost incessantly tormented by severe pain in the abdomen, in which nothing gave relief. On inspecting the body after death it was found that immediately under the spot on the right side of the abdomen, which had been the seat of the shingles and to which the subsequent pain had been referred, adhesions had taken place, and no doubt remained that these pains had been occasioned by the mechanical dragging of these attachments." Amongst 23 cases of chlorosis is included one in which the patient was "a male of seventeen, who had all the character of this disease except that which is peculiar to the female sex." He recovered, as girls do, under aloes and iron. "Deficient secretion of tears" has given as its synonym "Xerophthalmia," but without, unfortunately, any explanation as to the features of the disease in question. There were two cases. Finally, it must be noticed that five patients were under treatment for "old age," and that four of whom died of the malady. Professor Humphry may be interested to know, if he has not already found the passage, that "the common symptoms characterizing the disease of mere old age were frequent rigors, frequent and long-continued jactitations, producing a state of considerable suffering, and wearing out the residue of life by a sort of hectic fever." Their ages were from 80 to 99.

To the tables from which the above facts are quoted the

following note is appended, the concluding sentences of which are well worthy of attention at the present day :

“ In constructing these Tables, the author has, perhaps, exposed himself to criticism, in point of technical nosology. If so, it has not been from want of a due sense of the utility of methodical precision, for he sets a high value on nosology, not only as it assists in discriminating and ascertaining the nature of diseases, but as it contributes to improve and enlarge those comparative views of them which it has been the principal end of this communication to recommend and apply. He has accordingly had regard to it in these Tables. But as they were originally drawn up for his own private satisfaction, and as he deems the *phænomena* of the human body in a state of disease to be the most anomalous branch of nature, he neglected the niceties of classification, and in offering them to the public, he feels more studious of that perspicuity and fidelity which may render them intelligible and available to the plain and practical reader, than to strain them into a conformity with system.”

No. III.—*The supposed influence of Pregnancy on Retentiveness of Life.*

I find in an entomological work the statement that it is especially difficult to kill female moths when containing eggs. A similar opinion is held by butchers that pregnant animals always “die hard.” I have been assured that a ewe in lamb will, after division of the vessels in the neck, continue to struggle much longer than would be the case in one not pregnant. There is also a widespread belief that pregnant females seldom die of disease ; that they withstand contagion better, and pass through attacks of illness—whether inflammations or specific fevers—with more security than those who are not so. It may easily be the fact that these supposed observations have no real foundation, and are the result merely of preconception on the part of the observer. They are, however, worthy of attention, and the existence of similar belief in such different departments seems to claim investigation. Before attempting any explanation it is desirable to re-examine the facts.

A CATECHISM OF SURGERY; WITH CASES FOR DIAGNOSIS.

PREFATORY NOTE.

I HAVE written the following Questions and Answers, with Cases for Diagnosis for the help of advanced students and young practitioners. They are intended for use in recapitulation and self-examination and not as a substitute for reading, and far less for ward study. The student who wishes to derive advantage from them will do well to dwell on the questions with patience, and to attempt their answers for himself before reading those which I have given. The "cases for diagnosis" may count also as Case-records, since they are all careful narrations of actual facts. In most instances they will be given from my own observation, but in a few I shall take cases recorded by others. It is my intention to devote in each number of the ARCHIVES about the same space to this department which the present pages occupy. I shall intentionally avoid any arrangement of subjects, shall not attempt to discriminate in much detail between "Medicine" and "Surgery," since my catechism is intended for the assistance of those who are seeking a wide and general acquaintance with professional subjects.

No. I.—*On the Sources of Vaccine Lymph.*

It has long been known that "cow-pox" is met with only on the udders of cows, and never on the scrotum or other parts of bulls. What explanation can be given of this fact?

"Cow-pox" would appear to be almost extinct. Great efforts have been made to procure a fresh supply of lymph from a cow affected with the natural disease, but neither in England nor on the Continent can any animal* so affected be found.

* I shall refer to Dr. Cruikshank's recent report on some examples of it at a future time.

What explanation can be given of this curious extinction of a disease which was fairly common in Jenner's time?

Mention the possibilities as regards the original sources of the lymph now in use as vaccine.

ANSWERS.

If we suppose that "cow-pox" was a disease communicated to the cow by the hands of milkers suffering from variola, the facts will be fully explained.

The same explanation will apply also to the second question. Milkers now never suffer from small-pox, and consequently no cows are infected.

The vaccine now in use may be derived :—

1. From the vesicles of cows affected with "cow-pox" (a specific disease originating in them). This is not probable.

2. From vesicles produced on the udders of cows by contagion from the hands of milkers suffering from small-pox.

3. From vesicles produced intentionally on the cow by the inoculation of variolous matter (Badcock's lymph).

4. From vesicles produced intentionally on the cow by the inoculation of human vaccine (*i.e.*, modified variola).

No. II.—*The Uses and Abuses of Splints.*

1. Mention the several purposes for which splints are used in fractures.

2. Are splints needed in all cases of fractures of bones?

3. Are they ever injurious?

4. In what cases should they be avoided?

5. In what forms of fracture are splints most needed for the purpose of extension?

6. How would you treat a fracture in which you had decided that splints would be injurious?

ANSWERS.

1. (1) For extension; (2) To give support and prevent movement; (3) But rarely to secure co-optation by making pressure.

2. No; they are needed only when one or other of the above indications can be fulfilled.

3. Unless really necessary all pressure on injured parts and all prolonged fixation and enforced rest are directly injurious. Especially may swelling of the limb and stiffness be the results in elderly persons.

4. Splints may be avoided in all cases in which it is difficult to decide whether there is fracture or not, for in these there is neither displacement nor mobility. Fractures through the expanded joint-ends of bones are often better without splints, *e.g.*, the head of humerus and carpal end of radius.

5. Whenever there is no tendency to shorten, extension is worse than useless, *e.g.*, when one of a pair or of several is broken, *e.g.*, one bone only of the forearm, one only of the leg, or one of the metacarpals.

6. Apply a spirit lotion, and keep the limb at rest on a cushion without any sort of constriction.

No. III.—*On the Diseases of Arteries.*

1. Distinguish between primary fatty degeneration of the arterial coats and atheroma.

2. Is there any difference as to the arterial coat affected in each?

3. How would you demonstrate this difference in the post-mortem room?

4. Is primary fatty degeneration confined to the inner coat?

5. Is it a frequent cause of aneurism, thrombosis, or apoplexy?

ANSWERS.

1. Passive, primary, or simple fatty degeneration is usually a senile change, or occurs in states of impaired vitality when other tissues also suffer. It is not attended by the evidences of inflammation, thickening, swelling, or central softening, which are seen in atheroma.

2. Atheroma begins in the deeper part of the inner coat, and fatty degeneration in the epithelial or innermost layer.

3. By stripping off the innermost layer. In the case of atheroma this would leave the diseased patch behind, whilst

in the case of fat it would take it away and leave healthy tissues beneath.

4. No ; it may occur also in the muscular coat, but is less frequently seen in it.

5. It often affects the cerebral arteries, and as it occurs usually to the aged it is a frequent cause of apoplexy from rupture. It is not a common cause of either thrombosis or aneurism, excepting of minute aneurisms in cerebral vessels.

No. IV.—*On the Diseases of Arteries.*

1. Mention the principal diseases to which the coats of arteries are liable.

2. In what part does atheroma begin ?

3. What vessels are most liable to suffer from atheroma ?

4. What are the supposed causes of atheroma ?

5. Is it an inflammation or a degeneration ?

6. What is meant by primary calcification of arteries ?

7. In which coat does primary calcification begin ?

8. What arteries are more usually affected by primary calcification ?

9. To what diseases may the several forms of arterial disease lead ?

ANSWERS.

1. Fatty degeneration, atheroma, and primary calcification.

2. Atheroma begins in the deeper layers of the inner coat.

3. Atheroma may occur in any artery, but it most frequently seen in the aorta.

4. It is supposed to be caused by strain of the vessels, but is perhaps predisposed to by syphilis and by intemperance.

5. It is distinctly a process of chronic inflammation, and may be attended by considerable swelling, and followed by softening and ulceration.

6. Primary calcification is a term applied when no preceding atheroma has been present.

7. It begins in the fibres of the muscular or middle coat.

8. The arteries of the limbs, and especially those of the lower limbs, are much more liable to primary calcification than the aorta.

9. Calcification occludes the artery, and may lead to gangrene ; or it makes the coat brittle, and may lead to rupture and apoplexy. Atheroma may cause aneurism, or if ulceration is present, may lead to embolism.

No. V.—*On Amputations.*

1. What is the best method of amputation for general use ?
2. Why is the circular method but rarely done ?
3. What is the objection to flaps by transfixion ?
4. What are the measurements for a Teale's amputation ?
5. What are the objections to Teale's method, and what its advantages ?
6. Is the method by "flap-skin, circular muscle" applicable to all parts ?
7. What should be the length of the skin flaps in relation to the circumference of the limb ?
8. In a circular amputation how far below the place of section of the bone should the skin be divided ?

ANSWERS.

1. By oval skin flaps and a circular sweep through the muscles.
2. The old circular method is tedious in performance, requires much painstaking, and may easily be so done as to leave too little covering.
3. Transfixion flaps are liable to subsequent hæmorrhage, as small vessels may have been divided close to the main trunk. This method also makes very large cut surfaces.
4. In a "Teale" the front flap is square, its sides equal to half the girth of the limb. The hinder flap is one quarter the length of the long one.
5. A "Teale" makes an excellent stump, and if exactly done the flaps are sure to fit, but it has the drawback that it sacrifices the length of the limb.
6. "Flap—skin ; circular—muscle," is applicable to almost all parts, and with modification as to the relative size of the two flaps, may be adapted to almost all cases.
7. Under ordinary conditions, and when the two flaps can

be cut of equal length, they should be one-third the girth of the limb.

8. One-third of the girth of the limb, or very nearly.

NO. VI.—*On Concussion of the Brain.*

1. What are the stages of Concussion of the Brain?

2. Describe the symptoms of the first stage.

3. What treatment would you adopt in it?

4. If a patient, having received a severe injury to the head from a fall, should die without regaining consciousness, what should you expect to find at the autopsy?

5. Under what circumstances would you bleed after injury to the head?

6. What are the best substitutes for bleeding?

7. In an ordinary case of severe concussion what symptoms would you seek for as indicating local injury?

8. What are the symptoms most characteristic of the reaction stage of a concussion case?

9. What symptoms in the reaction stage are of bad omen, and what do they imply?

ANSWERS.

1. The stage of collapse; the stage of reaction or the "sleepy stage"; the stage of convalescence.

2. The patient looks as if dead; is pale, with a feeble, fluttering pulse; irregular and weak inspirations; clammy skin and dilated pupils.

3. Put the patient under conditions to favour recovery of the circulation, and wait.

4. Contusion or laceration of one or more parts of the brain.

5. If in the stage of full reaction there should be no return of consciousness, or it should be very imperfect.

6. Heat to the feet, cold to the head, and brisk purgatives.

7. Search should be made for symptoms of paralysis. The limbs should be tested; the pupils, the muscles of the eye-balls, and those of the face (7th nerve) should be examined. If it is practicable ascertain whether the patient can see and hear on both sides.

8. A tendency to sleep, with the possibility of being roused. The patient sleeps on his side, not on his back. He can be got to answer questions and to take food, but immediately goes to sleep again if left alone.

9. If the patient sleeps on his back instead of his side; if he will not answer questions; if he passes his urine into the bed. These symptoms imply contusion of brain, and make recovery doubtful.

No. VII.—*On Piles or Hæmorrhoids.*

1. What are piles?
2. What is the difference between external and internal piles?
3. What is meant by the term “strangulated piles”?
4. What are the symptoms of piles in an early stage?
5. What is meant by “a skin pile,” or “shrivelled pile”?
6. What are bleeding piles?
7. What dangerous symptoms may be produced in cases of aggravated or neglected piles?

ANSWERS.

1. Piles are essentially varices at the anus. The dilated veins become, however, embedded in thickened and vascular mucous membrane, and the arteries enlarge also.

2. There is no clear distinction between external and internal piles, and the terms had better be disused. All piles begin internally.

3. Strangulated piles are piles which have become protruded and gripped by the sphincter, and are so much swollen that they cannot be returned, or if returned, will not remain; this condition constitutes what is popularly known as “an attack of piles.”

4. The early symptoms of piles are a sense of fulness at the anus, especially noticed after defecation; mucous discharge, and occasional bleeding.

5. A skin pile is a fold or lobule of mucous membrane, which has become cuticular after the extrusion and shrivelling of a pile.

6. "Bleeding piles" are piles which bleed from the mucous surface during the pressure produced by defecation.

7. The patient may become exsanguined and debilitated to an extreme degree.

No. VIII.—*On Piles or Hæmorrhoids.*

1. If piles are excised is the bleeding venous or arterial?

2. Is the excision of piles a safe procedure?

3. What is the most generally suitable operation for the removal of piles?

4. Is the hæmorrhage from "bleeding piles" venous or arterial?

5. What is meant by the popular expression, "blind piles"?

6. What is "an attack of piles"?

7. Does thrombosis ever occur in piles?

8. What other methods may be adopted for the radical cure of piles besides their ligature?

ANSWERS.

1. It is arterial. The arteries and veins travel in company and are both dilated.

2. No prudent surgeon would ever excise piles without special precautions against bleeding.

3. An operation which consists in ligature of the pile after its base has been isolated by an incision where the skin and mucous membrane join.

4. When piles bleed the blood comes chiefly from surface capillaries, but it may be from small arteries. Very rarely indeed is it venous.

5. A "blind pile" is a pile which never bleeds.

6. An attack of piles usually designates the strangulation of extruded piles, but it may now and then be applied to the occurrence of thrombosis.

7. Yes; the blood in a large dilated vein may coagulate. Absorption will follow, and the pile become obliterated. Sometimes, but not often, inflammation follows the thrombosis.

8. Piles may be removed by the actual cautery, they may

be cut away after clamping, they may be crushed, or they may be destroyed by the free application of fuming nitric acid. The last is applicable to small, very vascular piles, when they occur in debilitated subjects.

No. IX.—*On Conical Stumps and on Amputation.*

1. What are the usual causes of conical or "sugar-loaf" stump?
2. In what parts is it most likely to occur?
3. May it be reproduced after a second operation?
4. What points should be carefully attended to in all amputations?
5. Give the principal rules for success in the performance of amputations.

ANSWERS.

1. It may be the result of sloughing of flaps (rare), or of a badly performed operation (still more rare), or of the continued growth of the bone in young persons (common).

2. The upper arm and the leg, because the humerus and the tibia grow chiefly from their upper ends.

3. In growing subjects conical stumps may be reproduced, and it may be necessary to have the bone shortened two or even three times at intervals of a few years.

4. (a) To secure plenty of covering for the bones.

(b) To retain only sound structures.

(c) To divide the parts cleanly, and to cut all arteries transversely.

(d) To secure all arteries most patiently before closing the stump.

(e) To provide liberal drainage.

(f) To give adequate and even support to the stump, without undue pressure.

5. Be very careful to have the circulation efficiently controlled by tourniquet or otherwise, so that you may not be hindered by bleeding.

Be very deliberate at all stages.

Have your assistants well instructed what to do.

No. X.—*Concussion of the Brain.*

1. What is meant by the term “sleep-stage of concussion”?

2. What symptoms are of bad import in a concussion case?

3. What do you mean by coma?

4. In what does coma differ from the sleepy stage of concussion?

5. Can a patient in the first stage of severe concussion be roused to answer questions?

6. In a case of uncomplicated concussion does the patient usually wet his bed?

7. What are the commoner complications of concussion of the brain?

8. In a case of severe concussion what symptoms would make you suspect fracture of the base of the skull?

9. In the collapse of the first stage of concussion are the pupils contracted or dilated?

10. What is the state of the pupils in the re-action or sleepy-stage?

ANSWERS.

1. The stage of reaction in which, with full return of circulation, there is a remarkable tendency to normal sleep.

2. Profound insensibility; stertor; recovery of circulation without recovery of consciousness.

3. Profound insensibility, independently of collapse.

4. In the sleepy stage the patient may be roused; in coma, he cannot.

5. No. He is as if nearly dead, and cannot be roused, but it is from collapse, not coma.

6. No. If he does, it is indicative of an aggravated case.

7. Fracture of the skull; paralysis of special nerves; contusion or laceration of the brain.

8. Bleeding from ear or nose; ecchymosis of the eyelids; deafness; facial paralysis.

9. Always dilated, for the patient is as if dead.

10. Moderately contracted as in normal sleep, but ready to dilate at once if the patient be roused:

No. XI.—*A Case for Diagnosis.*

An old gentleman of 63 is almost blind. He has very small pupils, and after repeated use of atropine they dilate but very little. He has bare perception of light, and the two eyes are almost exactly alike. He has had amputation through the thigh, and subsequently at the hip joint on account of old, standing disease of the bones of the leg. He says that he nearly died of secondary hæmorrhage after the last amputation, and to the debility which followed it he attributes the final failure of his sight. It appears, however, on cross-questioning him that his sight has been weak all his life, and that the deterioration has been very gradual. Two of his brothers, both older than himself, are blind, and a sister has lost one eye, and is defective in the other. Excepting that he is a little deaf he has no other symptoms of disorder of the nervous system, and says that he never knew what a headache was. Until about a year ago he says that he could see by the aid of a strong magnifying lens to read large print to one of his blind brothers.

What is the probable cause of the failure of sight?

On what further points ought inquiry to be made in order to complete the history?

ANSWER.

It would be desirable to know whether any of the patient's predecessors were blind. Whether his father and mother were first cousins, and whether, in the earlier stages of his disease, he experienced any special difficulty in seeing by artificial or poor light.

(The answer to all these questions in the case before us was in the negative.)

The very slow progress and almost lifelong history of defect make it almost certain that the disease is that form of choroido-retinitis, commonly known as retinitis pigmentosa; and the occurrence in three or four members of the same family of children gives strong support to this diagnosis. So also does the entire absence of other symptoms of disorder of the nervous system. It is exceptional, however, that there

should be no history of night-blindness, and that no predecessors are known to have suffered.

Facts additional to the case-statement.

On ophthalmoscopic examination the retina was found covered with black pigment, arranged in the form of bone-corporuscles, stars, or spiders. The optic discs were pale and waxy, and the central vessels diminished to mere threads.

No. XII.—*Case-statement for Diagnosis.*

A gentleman of 29, of fair complexion, of gouty family. He gives the history that when a boy at Eton he was six weeks in bed with an acute attack of what was called eczema. He believes that he also had eczema in infancy. He now frequently suffers from a slight form of acne on the forehead, attended by peeling and cracking of the skin. He has observed that all wines bring out the eczema, and he mentions one particular place of residence where he invariably gets it, in consequence, as he believes, of the water containing iron. The eruption now usually comes on the face, but sometimes on the arms also. It itches so much, and is so invariably aggravated by his scratching, that he always sleeps in gloves. The disease for many years has been kept in check, and for the most part cured, by local applications.

Is this a case of Hebra's Prurigo?

Is it usual for the eczema of infants to persist or to relapse in after life?

What principles of local and general treatment should be adopted?

ANSWER.

The case is one of common eczema, which has been neglected, in a patient of a pruriginous skin and very prone to scratch. It is not very uncommon for the eczema of infants to persist in a state of incomplete cure, or, after cure, to recur in the course of years.

The acute attacks in infancy, and again in boyhood, prove it to be really eczema, and its amenability to the remedies for that disease confirms the diagnosis. The patient should

be careful as to his place of residence. A moist air, and very probably the seaside, would suit him. He should, if possible, always use rain water to wash with, and should put a little borax into it. He should avoid wine, beer, milk, sugar and fruits. Arsenic will probably make him worse. Very weak lotions containing tar will be suitable. Above all, he must never scratch or rub. In order to avoid he should always keep a weak tar wash at hand.

No. XIII.—*Dean Swift's Illness. A Case for Diagnosis.*

Dean Swift was born in 1667. He records: "Before I was twenty I got a cold, which gave me a deafness that I could never clear myself of; my left ear has never been well since."

He described his "two life-long enemies" as "a giddiness and coldness of stomach." His accounts as to their beginning are not uniform. Sometimes he says that the giddiness came first, and sometimes that the deafness did so, and sometimes he attributes the onset to catching cold, and sometimes to having "eaten a hundred golden pippins at a time." Respecting the latter notion Dr. Johnson sagaciously writes: "The original of diseases is commonly obscure, and almost every boy eats as much fruit as he can get, without any inconvenience."

In 1708 Swift told Archbishop King that he had been persecuted with "a cruel distemper of giddiness" in his head for more than seven weeks, which would not suffer him to write or think of anything. These attacks recurred, with intervals of two or three years. In 1727 he had a nine weeks' attack, in 1733 one of seven months, and in 1737 he recorded that he had been "unfitted for human conversation by giddiness," &c., for seven weeks.

His "fits" were attended by giddiness and sickness, and he used to take brandy for their relief. In 1708 he uses the expressions, "Often giddy, God help me;" "Brandy for giddiness;" "Horrible sick;" "Much better, thank God, and M. D.'s prayers;" "An ill fitt, but not to excess;" "Giddy fitt, and swimming in head. M. D., and God help me;"

"Terrible fitt, God knows what may be the event." Swift lived to be seventy-eight, having been during the last year of his life in a state of senile dementia. An attack of convulsions (his first) preceded his death.

What was the nature of his ailment?

ANSWER.

His attacks were clearly of the nature of Menier's symptoms, or "Labyrinthine vertigo" (see Dr. Bucknill in *Brain*, Jan., 1882). They were of unusual severity. They illustrate the facts: That violent sickness as well as giddiness may attend the condition; that long intervals may occur between the attacks; that the attacks may vary very much in severity; that the liability to them may persist continuously for weeks, or even months, and then pass away; that they are not indicative of any aggressive brain disease, although for the time incapacitating the sufferer.

Swift's intellect remained clear and vigorous till within a year or two of his death. His frequent and severe attacks of giddiness may have had some effect upon his temper, and may have increased his tendency to gloom. There is no proof that they did so, or that the ear disease which caused them had anything to do with the brain disorder which closed his life. He was never, until the last, really insane, was never epileptic, and never had paralysis. He himself summed up his conditions in the following line:

"Vertiginosus, inops, surdus, male gratus amicis."

No. XIV.—*A Case for Diagnosis.*

A man aged 50, who was in good health, and had previously had good sight, was one day engaged, for a longer time than usual, stooping over a bench, cutting leather. On the following morning he had the subjective symptom of drops of water falling rapidly, one after the other, from his hat brim. This appearance was before his left eye only, and it continued all day, and more or less for several days. Next he saw all flames of a green or blue colour, and then he had "electric flashes of light" in his eye. When examined three weeks

later, he could perceive objects only in the lower and inner parts of the field. There was no increase of tension.

There had been no pain in the eye, but a certain amount of circumorbital aching at times.

What was the probable nature of his ailment?

How do you explain his several symptoms?

ANSWER.

The symptoms which attracted the man's attention indicated some cause of irritation in the retina. As it increased and was soon followed by loss of sight in a large part of the field, the most probable lesion was an advancing detachment of the retina. The circumstances under which the symptoms began, stooping forwards, were exactly those likely to cause retinal detachment. The absence of pain and of increase of tension negative the suspicion of glaucoma. The alteration in the colours of flames was not the same thing as the coloured rings seen in glaucoma, and was to be explained by disturbances in the retinal elements.

Statement additional to case.

The ophthalmoscope confirmed the diagnosis suggested in the answer. In the upper half of the fundus the retina was detached by large effusion between it and the choroid. Over the whole yellow-spot-region the retina was in ripples, exactly like a table-cloth not laid smoothly, the effusion being only small in quantity. It is remarkable that it was the *upper* part of the retina which was detached.